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**Understanding West African migrant nurses' work experiences in the United Kingdom:
A phenomenological study**

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A thesis submitted for the award of the degree of Doctor of Philosophy (PhD)

Department of Organizational Psychology

Birkbeck, University of London

August 2020

Declaration of authorship

I declare that this thesis and the works presented in it are entirely mine. I have acknowledged appropriately where I have consulted the works of others.

Chinedu Uwabuiké

Signature

Date:

Abstract

Previous research on migrant nurses in the United Kingdom found high levels of dissatisfaction and disappointment with their work experiences. Drawing on theories of exchange relationships, the current research took a qualitative approach to understand more about migrant nurses' expectations and experiences at work in the United Kingdom. In particular, the researcher explored the role of culture in West African migrant nurses' perceptions of exchange relationships and their responses to perceived unmet expectations and breach. The following research questions were addressed: *(1) What reasons and expectations do West African nurses use to explain their migration to the UK? (2) How might cultural conceptions explain West African migrant nurses' perceptions of experiences at work in the United Kingdom? (3) How do West African migrant nurses manage conflicts between their expectations and experiences at work?*

The research employed a two-studies' research design, with data collected using semi structured interviews in two separate phases from a purposive sample of fifteen (N=15) West African migrant nurses working in the South East of England, including London. As an exploratory phenomenological enquiry, template analysis (King, 2012) was used in Study One to answer research question 1 and interpretative phenomenological analysis (Smith, Flowers, and Larkin, 2009) was used in Study Two to answer questions 2 and 3.

The findings suggest the nurses' reasons for migration to the United Kingdom reflected their premigration expectations which then formed the basis for their evaluation of their experiences at work. The research highlighted the complex interactions of expectations, cultural understandings, and experiences. West African migrant nurses' deep hold on their original cultural values was not only reflected in their perceptions of experiences at work interactions and processes but also in their emotional and behavioural responses to these experiences. The qualitative nature of this research enabled the evolvment of insights into the nurses' cultural perceptions of power relations and how these perceptions impacted on their relationships at work. The nurses' feelings of high leader member exchange differentiation reinforced their perceptions of negative experiences and further increased their isolation at work. While the nurses had anticipated high trust-based leader member exchange relationships which could have positively impacted on their perceptions of organisational processes, their real experiences of high leader member exchange differentiation rather created tension and distrust for the nurses. These gaps in the nurses' exchange relationships, accounted for their further feelings of lack of organisational social support at work.

However, the nurses' adoption of a non-voice (repressive), avoidance coping responses to their perceptions, created further interactional and socialisation vacuums that denied them the high-quality trust-based manager -employee exchange relationships that they had anticipated. This, in turn, limited the nurses' accesses to the organisational resources, information, and engagement necessary for their wellbeing and career development which was part of their pre-migration expectations.

Therefore, this research proposes practical steps that the management of organisations employing migrant nurses could apply to increase understanding and management of the cultural sensitivities of the nurses' and their support needs, to reduce tension and distrust at work and consequently enhance the nurses' engagement in and membership of their

organisations. This research proposes that it is necessary for the effective leadership of organisations to champion the processes of initiating, building and sustaining trust between migrant nurses, their managers and colleagues. It is important for management to assess and appreciate the nature and forms of organisational support that migrant nurses anticipate at work. The nature of this support may not be obvious as one would expect but rather present in implicitly coded expectations. The research therefore proposes support for prospective nursing home managers as part of their induction, and overseas/migrant nurses on adaptation programmes in the United Kingdom, to develop cultural intelligence (CQ) for the motivational mindset to embrace cultural sensitivities. This will enhance effective appreciation and management of cultural sensitivities in their organisations.

Acknowledgements

It is not by might, nor by power but by My spirit, says the Lord of hosts (Zachariah 4:6).

I am indeed lost for words in appreciating the support and encouragement of men and women that the Lord of hosts used to remove the “stone” for Him to speak life into this my lifetime journey of conducting a PhD research. My everlasting THANKS and GLORY to God. To my parents, Late Chief Clifford Oguzie & Late Lolo Fidelia Onugo Uwabuiké, I remain grateful for your passion and prophetic resolve, that your son, will go to “Ala Bekee”. Mama, your favourite prophetic song in confirmation of this remains fresh in my memory today as it did those years ago. I shall never forget your sacrifices in denying yourselves luxuries of life then to start me well in my journey through academics. To my uncle, late Mr Felix Uwabuiké, I consider this as part of your legacy. To my siblings, Ken, Jeff, and Isaac, you are in my thoughts.

To my supervisor, Dr Julie Dickinson, I cannot thank you enough for being there for me when the mood was down, and the weight seemed overwhelming. Julie, when they say angels of God walk the earth doing good, I attest I have seen and worked with one. To my other supervisors, Dr Kate Mackenzie Davey and Dr Kevin Teoh, thanks for your constructive reviews and feedback that sharpened my thinking. I am also full of gratitude to members of my faculty, Dr Laura Thompson, Dr Rebecca Whiting, Prof. Almuth McDowall, Dr Caroline Kamau, Dr Venessa Iwowo for your words of encouragement. To Ms Jean Devaney, thanks for recommending approvals, at various vital times, of my applications for the departmental

conference grants which enabled me to share my research ideas with peers at British Academy Management conferences in Cardiff and Belfast, and at Harvard, Boston USA.

To Prof Kevin Ibeh, I say thank you for your kind words of wisdom and encouragement to me at different times during this journey. To Dr Max Lempriere, thanks for proofreading the thesis. To Mrs Wendy Harding, may God continue to bless you and household for being an inspiration to this journey. Also, I remember your late husband and my dear friend, John, as he continues to rest in the bosom of our Lord. To Mr Chris & Mrs Linda Alcock, Rev Norman Grigg, Rev Robert Blackhall, Mrs Sarah Bowen, Ms Pat Bogle, Dr Stella Iwuji, Mr William Forster, Mr Ernest Aubee, I pray that God continue to uphold you all for believing in me. I remember also in my prayers, late Rev (Prof) Peter Stevens and late Rev Robbie Bowen.

Table of Contents

	Page
Declaration of authorship.....	1
Abstract	1
Acknowledgement.....	3
Table of Contents.....	4
List of Abbreviations	9
List of Tables.....	10
List of Figures	11
Chapter 1: Introduction.....	12
1.1 Introduction	12
1.2 Research background and context	13
1.3 Diversity challenges at work.....	15
1.4 Intergroup relations at work.....	16
1.5 Research sample and location.....	17
1.6 Research objectives (ROs).....	17
1.7 Research methodology and design.....	18
1.8 Significance, originality, and contribution.....	18
1.9 Structure of the thesis.....	19
1.10 Framework of studies one and two	20
Chapter 2: Literature Review (1)	22
2.1 International migration and migrants' experiences.....	22
2.1.1 The neoclassic economic migration theory.....	22
2.1.2 The international labour market migration theory.....	23
2.1.3 Deciding to migrate.....	24
2.1.4 Categories of migrants.....	25
2.1.4.1 Forced migrants.....	25

2.1.4.2 Voluntary migrants.....	25
2.2 African international migration patterns.....	27
2.2.1 Socio-economic wellbeing of the people.....	27
2.2.2 Poor leadership and governance.....	29
2.2.3 Pressures from families.....	30
2.2.4 Attractions from western countries	30
2.3 United Kingdom: The need for migrant nurses.....	31
2.3.1 Geriatric statistics.....	31
2.3.2 Shortages of indigenous trained nurses	32
2.4 United Kingdom: Nursing and care home structures.....	33
2.4.1 United Kingdom: Registrations of nursing and care homes.....	33
2.4.2 United Kingdom: Migrant nurses' adaptation and admission.....	34
2.5 United Kingdom: Background of migrant nurses' experiences.....	35
2.5.1 Disproportionate role assignments.....	36
2.5.2 Micromanagement and control.....	38
2.5.3 Transparency issues.....	39
2.5.4 Measuring development	40
Chapter 3 Literature Review (2).....	43
3.1 Understanding migrants' expectations and experiences: The contribution of theories of exchange relationships.....	43
3.1.1 The psychological contract and types.....	43
3.1.1.1. Transactional contract.....	45
3.1.1.2 Relational contract	46
3.2 Organisational justice and migrants' experiences at work.....	47
3.2.1 Procedural organisational justice.....	49
3.2.2 Distributive organisational justice.....	50
3.2.3 Interactional organisational justice.....	51
3.3 Perceived organisational support (POS).....	51
3.4 Cultural influences on perceptions of work processes	53
3.5 Cultural influences on perceptions of breach in exchange relationships....	56
3.6 Cultural influences on coping adjustments to exchange breach perceptions	58
3.7 Organisational commitment : A gauge for employee perception of work...	59
3.7.1 Affective organisational commitment	60
3.7.2 Continuance organisational commitment.....	60
3.7.3 Normative organisational commitment	61
3.8 Migrants' evaluation of experiences and engagement at work.....	63
3.8.1 Organisational leadership influences	64
3.9 Leader-Member Exchange (LMX).....	65
3.9.1 LMX: Developing and sustaining the exchange relationship.....	66
3.9.2 The LMX Differentiation (LMXD): Consequences on trust	70
Chapter 4 Perceptions in organisations and cultures.....	74
4.1 Subjectivity of perceptions.....	76
4.2 Perceptions in organisations.....	76
4.3 Perceptions and cultural conceptions.....	78

4.4 Migrants: Cultural conceptions and destination adjustments.....	83
4.5 Migrants: Acculturation and work wellbeing	84
4.6. Dimensionalising cultural values.....	85
4.6.1 Kluckhohn and Strodtbeck (1961).....	86
4.6.2 Hall (1981,1990).....	86
4.6.3 Schwartz cultural model (1992;1994).....	87
4.6.4 Trompenaars and Hampden-Turner model (1998).....	87
4.6.5 House, Hanges, Javidan, Dorfman and Gupta (2004)GLOBE.....	87
4.6.6 Hofstede's cultural dimensions (1980;1991).....	88
4.6.6.1 Individualism vs Collectivist (IDV-COL).....	89
4.6.6.2 Power Distance (PD)	90
4.6.6.3 Uncertainty avoidance (UA).....	91
4.6.6.4 Masculinity -Femininity.....	92
4.6.6.5 Challenges to Hofstede's dimensions.....	95
4.6.6.6 Hofstede's cultural dimensions and the present research	98
4.7 West Africa: Indigenous values and beliefs.....	99
4.7.1 West African patriarchal social values.....	100
4.7.2 West African organisational social values	101
4.7.3 West African traditional values and modern management practices....	102
4.7.4 West African traditional supernatural beliefs.....	104
4.8 Collective summary, gaps, and research questions.....	104
Chapter 5 Research Methodology and Design.....	106
5.1 Research epistemological and ontological underpinnings.....	106
5.2 The choice of qualitative research approach	107
5.3 Research design and data collection.....	109
5.3.1 Phases of data collection.....	109
5.3.2 Phase one data collection	109
5.3.3 Phase two data collection.....	110
5.3.4 Semi-structured interviews.....	110
5.3.4.1 Transcription of audio interviews.....	111
5.3.4.2 Techniques of analysis.....	111
5.4 The researcher's reflexivity and data validation.....	112
5.5 Purposive sampling	113
5.5.1 Participants' inclusion criteria.....	114
5.5.2 Participants' exclusion criteria	115
5.5.3 Recruitment of participants.....	115
5.5.3.1 Self-selection	115
5.5.3.2 Snowballing.....	116
5.6 Participants' invitation and consent	116
5.7 Ethical considerations	117
5.8 Anonymity of participants	118
Chapter 6 Study One.....	120
6.1 Data collection	120
6.2 Data analysis.....	121

6.3 Modification of template.....	124
6.4 Findings	127
6.4.1 Theme one: Upskilling and improving on knowledge and skills.....	127
6.4.2 Theme two: Safe working environment.....	131
6.4.3 Theme three: Sustaining family economies and financial needs.....	133
6.4.4 Theme four: Personal and family social prestige.....	138
6.5 Discussion (RQ1).....	139
6.5.1 Aspirations to improve skills and knowledge	140
6.5.2 Aspirations to sustain family economies and financial needs.....	143
6.5.3 Aspirations to work in safe work environment	144
6.5.4 Aspirations to enhance personal and family social prestige.....	145
6.6 Implications of Study One	146
6.7 Mapping link between Study One and Study Two	146
Chapter 7 Study Two Method	147
7.1 Data collection	147
7.2 Interview guide.....	148
7.3 Analysis of data.....	150
7.4 IPA and organisational behaviour research.....	151
7.5 IPA: Inductive, interrogatory, and reflective processes.....	152
7.6 IPA: Hermeneutic theory of double interpretations	152
7.7 IPA: Present research processes of analysis.....	154
7.7.1 Process stage one (Preparing the data for analysis)	154
7.7.2 Process stage two (Coding the data)	154
7.7.3 Process stage three (Generating the descriptive themes).....	155
7.7.3.1 Case by case analysis of individual nurse's data	156
7.7.3.2 Participants' profiles.....	157
7.7.4 Process stage four (Clustering of themes)	162
7.8 Summary of the data analysis processes	164
7.9 Challenges of the processes	166
7.10 Mapping reflective interpretations of composite superordinate themes.....	166
Chapter 8 Study Two: Findings (RQs 2& 3).....	168
8.1 Superordinate theme one: Power and Leadership.....	169
8.1.1 Descriptive theme 'manager-subordinate power relations'.....	170
8.1.2 Descriptive theme 'organizational lines of authority'.....	174
8.1.3 Descriptive theme 'age related values at work'	178
8.1.4 Descriptive theme 'managing organisational processes'.....	180
8.1.5 Generation of the superordinate theme 'power and leadership'.....	182
8.2 Superordinate theme two: Family life at work.....	183
8.2.1 Descriptive theme 'communal bonding and family relations'.....	184
8.2.2 Descriptive theme 'organisation/supervisor support'.....	188
8.2.3 Descriptive theme 'team membership and interpersonal relationships'....	191
8.2.4 Generation of the superordinate theme 'family life at work'.....	193

8.3 Superordinate theme three: Caution in management of conflicts.....	195
8.3.1 Descriptive theme ‘soft treading on concerns at work’.....	196
8.3.2 Descriptive theme ‘rationalisation of choices’.....	201
8.3.3 Generation of the superordinate theme ‘caution in management of conflicts’.....	203
8.4 Study Two: Findings (RQ3)	204
8.4.1 Superordinate theme four: Process defect and trust issues.....	205
8.4.1.1 Descriptive theme ‘feelings of betrayals’.....	206
8.4.1.2 Descriptive theme ‘feelings of doubts and shock’.....	209
8.4.1.3 Generation of the superordinate theme ‘process defect and trust issues’.....	215
8.5 Superordinate theme five: Wellbeing and organisational commitment.....	
8.5.1 Descriptive theme ‘feelings of despondency, stress, emotional labour and presenteeism’.....	216
8.5.2 Descriptive theme ‘depletion in extra role and organisational citizenship behaviours’.....	218
8.5.3 Generation of the superordinate theme ‘wellbeing and organisational commitment’	223
8.6 Superordinate theme six: Positive reframing.....	229
8.6.1 Descriptive theme ‘social-cultural and spiritual sense of being.....	231
8.6.2 Descriptive theme ‘renegotiation of exchange expectations’.....	232
8.6.3 Generation of the superordinate theme ‘Positive reframing’	239
	242
Chapter 9 Discussion.....	245
9.1 Study One: Building expectations	246
9.1.1 Dimensions of nurses’ expectations and evaluation of experiences...	247
9.2 Study Two (RQs2 and 3).....	249
9.2.1 Superordinate theme one: Power and leadership.....	252
9.2.2 Superordinate theme two: Family life at work.....	258
9.2.3 Superordinate theme three: Caution in management of conflicts.....	260
9.2.4 Superordinate theme four: Process defect and trust issues.....	262
9.2.5 Superordinate theme five: Wellbeing and organisational commitment...	266
9.2.6 Superordinate theme: Positive reframing.....	271
Chapter 10 Conclusions and suggestions for further research and improvements in practice.....	275
10.1 Deeply held values in perceptions.....	276
10.2 Significances of power and authority bases.....	277
10.3 Organisational social support.....	278
10.4 Avoidance coping and disengagement.....	279
10.5 Primacy of trust.....	280
10.6 Occupational(mental) health concerns	283
10.7 Summary of research contributions to knowledge and practice.....	284
10.8 Suggestions for future research.....	286
10.9 Limitations of the research.....	286
References	288
Websites	375

Appendices	
Appendix (i) Participant recruitment notice	376
Appendix (ii) Participant formal letter of invitation	377
Appendix (iii) Participant consent form.....	378
Appendix (iv) Interview guide for study one.....	379
Appendix (v) Interview guide for study two.....	380
Appendix (vi) Birkbeck, University of London ethics form.....	382

List of Abbreviations

UK	United Kingdom
WafMNs	West African migrant nurses
PC	Psychological contract
OCB	Organisational citizenship behaviour
NHS	National Health Service
OBSE	Organisation based self esteem
OST	Organisation support theory
SET	Social exchange theory
LMX	Leader member exchange theory
LMXD	Leader member exchange differentiation
GDP	Gross domestic product
WHO	World Health Organisation
USA	United States of America
NMC	Nursing and midwifery council
RCN	Royal College of Nursing
CQC	Care Quality Commission
IELTS	International English Language Testing System
OTNs	Overseas trained nurses

IENs	Internationally educated nurses
IRNs	Internationally recruited nurses
IQNs	Internationally qualified nurses .
SDT	Self-determination theory
IPA	Interpretative phenomenological analysis
TA	Template analysis
JS	Job satisfaction
TBE	Transactional based expectations
RBE	Relational based expectations
PSS	Perceived supervisor support
POS	Perceived organisational support
CQ	Cultural intelligence
WLC	Work locus of control
COR	Conservation of resources theory
DA	Discourse analysis
RQs	Research questions
OJS	Organisational justice system
PD	Power distance
UA	Uncertainty avoidance
COL/IDV	Collectivist/ individualist
MUS/FEM	Masculinity/ Femininity
GDPR	General data protection regulation

List of Tables

Table 5.1 The demographics of West African nurses who participated in the research

Table 6.1 Study One initial codes and concepts from the nurses' data

Table 6.2: Study one final template showing themes from categories of coding from data

Table 8.1 Individual nurses key words, phrases, and sentences “power and leadership”

Table 8.1a Clustering of descriptive themes into superordinate theme “power and leadership”

Table 8.2 Individual nurses key words, phrases, and sentences “family life at work”

Table 8.2a Clustering of descriptive concepts into superordinate theme “family life at work”

Table 8.3 Individual nurses key words, phrases, and sentences “caution in management of conflicts”

Table 8.3a Clustering of descriptive concepts into superordinate theme “caution in management of conflicts”.

Table 8.4 Individual nurse’s key words, phrases, and sentences “process defect and trust issues”

Table 8.4a Clustering of descriptive themes into superordinate theme “process defect and trust issues”

Table 8.5 Individual nurse’s key words, phrases, and sentences “wellbeing and organisational commitment”

Table 8.6 Individual nurse’s key words, phrases, and sentences “positive reframing”

Table 8.6a Individual nurse’s key words, phrases, and sentences “positive reframing”

List of Figures

Fig 1.1: Research framework showing processes of Studies One and Two

Fig 3.1: The LMX in relation to its antecedents and outcomes.

Fig 4.1: Elements and processes of perception showing how understanding of events and actions could evolve (Culled from Bratton, Sawchuk, Forshaw, Callinan and Corbett ,2010:135)

Fig 4.2 Hofstede’s cultural dimensions of power distance, individualism and collectivism, uncertainty avoidance, femininity, and masculinity

Fig 4.3: Hofstede’s dimensions mapping cultural values of the United Kingdom and West Africa

Fig 4.4: Geo-political map of West Africa shows its nation states

Fig 6.1: The template analysis process (Study One)

Fig 7.1 Process of organisation and analysis of data (Study Two)

Fig. 8.1 Nurses’ evaluation, consequences, and adopted adjustments/coping

Fig 9.1 Nurses’ descriptive themes as clustered into six superordinate themes

Chapter 1: Introduction

“We live in cultures in the same way that fish live in water. Just as fish are said to discover water last, our cultural ways are often invisible to us” (Bolman and Deal, 2004:240).

1.1 Introduction

This chapter introduces the overall aims and objectives of the research. It introduces the research background and context, purpose, significance, and implications. It also introduces the research methodology/design and the exchange relationship theories applicable to the research.

With global shortage, high attrition of nurses (Kingma, 2001) and concerns on nurses' recruitment and retention (Lundh,1999), the United Kingdom, like most developed nations, relies on migrant nurses, to support its health manpower needs in the health and social care sectors (Aiken, Buchan, Sochalski, Nichols and Powel, 2004; Cameron, Armstrong –Stassen, Bergeron and Out, 2004; Mor Barak, 2011). Migrant nurses form one of the diverse groups working in the United Kingdom. Government legislations, guidelines and policies regulate the management of diversity-related issues in both public and private organisations (www.nmc.org.uk).

The Equality Act (2010) and other legislations in the United Kingdom are aimed at forging confidence about the rights, opportunities, and well-being of all employees in both public and private workplaces. However, according to O'Brien (2007), the experiences of migrant nurses in the United Kingdom do not suggest that government guidelines and legislation have provided the expected positive outcomes for migrant nurses. This is set against the background of a number of both qualitative and quantitative studies (Alexis and Vydelingum, 2005; Alexis, Vydelingum and Robbins, 2007; Likupe and Archibong, 2013; Likupe, 2006; Withers and Snowball, 2003) suggest that migrant nurses have negative experiences at work in the United Kingdom.

1.2 Research background and context

The context of a research project includes its participants and their demographics as well as a clear rationale for the choice of context (Guba and Lincoln, 1989). This research is informed by previous research findings on the experiences of migrant nurses in the United Kingdom. Migrant nurses' morale and motivation in the United Kingdom have been called into question by reports of discrimination and denial of opportunities in training and development. Migrant nurses' experiences were argued to have an equally negative impact on their work behaviour, including job satisfaction, job performance, organisational commitment, trust, and organisational citizenship behaviours (Adhikari and Melia, 2015; Cohen-Charash and Spector, 2001; Hegney, Plank and Parker, 2006; Liou and Cheng, 2011; Newton, 2012).

On the other hand, several studies (Cummins, 2009; Henry, 2007; Newton, Pillay and Hugginbottom, 2012; Tuttas, 2015) identified issues of concern regarding the inability of some migrant nurses to fit in properly because of difficulties in understanding the work culture of their host countries. This creates more concern for managers and policy makers regarding recruitment, motivation, and retention of migrant nurses (Montayre and Holroyd, 2017). Shortages and high attrition levels of nurses in the United Kingdom have on occasions, informed policy decisions to put nurses on the migration occupational shortage list (Donelan, Buerhaus, DeRochers, Dittus and Dutwin, 2008; Kigma 2001; Tregunno, Peters, Campbell, and Gordon, 2009), which is a policy that relaxes visa conditions for overseas nurses to come and work in the UK.

Allan and Larsen (2003) suggested a deeper examination is needed of migrant nurses' experiences at work, with an emphasis on their ethnic and cultural values to develop more understanding of their vulnerabilities and perceptions of experiences at work (Begley, Lee, and Hui, 2006; Ken and Vico, 2015). To date, while previous research (Allan and Larsen, 2003; Likupe, 2006; Likupe and Archibong, 2013; Shields and Price, 2002; Smith, Allan, Henry, Larsen, and Mackintosh, 2006;) focused and reported on the negative experiences of migrant nurses in the United Kingdom, no research has specifically focused on West African migrant nurses' experiences, especially on expectations and how they coped within the circumstances in the United Kingdom (Ogunsiji, Wilkes, Jackson, and Peters, 2012). These are issues, the present research sets out to explore. The choice of West Africa for sample in this research is based on its consideration as a regional society which in relation to identity, shares

“undergirding strength of...communal psyche, historical memories, legends, myths and symbols of dignity and wellbeing....reflected in a set of deep-seated and most cherished values”(Ling, 2008:3). Although sub-Saharan Africa (West Africa) currently consists of constituent independent post-colonial states, with aspects of differences in values, the peoples of this area, as with most African countries, share dominant values and beliefs, used to determine observable activities and interactions (Markus and Kitayama, 2010; Weiner Healy and Proctor, 2003; Simonson, Carmon, Dhar and Drolet, 2001).

In his thoughts on Africa as a society, Otite (1978) suggests reciprocal relationships and communalistic traditions which characterised the peoples of Africa as sharing common ways of life. Ahiauzu (1986) argues of the existence of an African thought-system. Further dominant shared values in Africa and by implication, West Africa as a society have been documented in studies (Agulanna, 2010; Matondo, 2012; Nyagua and Harris, 2008; Bassey and Oshita, 2010; Aju and Beddewela, 2020; Otite, 1978). The advantage of using the sample across the region as opposed to a single country, is also on the expectations that the findings would apply to migrant nurses from any of the countries given the existence of the dominant values as explained above. The adoption of the regional sample also enhanced the recruitment of adequate number of participants needed for the research.

The number of West African nurse migrants to the United Kingdom and other European countries and the United States has been on the increase but their perceptions of their experiences have been understudied (Aiken, Buchan, Sochalski, Nichols and Powel, 2004; Kent, 2007; Thomas, 2011). While the Hofstede’s cultural dimensions (Hofstede, 1980;1985;1991; <http://geert-hofstede.com/west-africa-ghnsl.html>; Kirkman, Lowe and Gibson, 2006), which suggested differences in values of culture between the UK and West Africa is introduced in this research, West African societal traditional values and beliefs were adapted to qualitatively explore the nurses’ experiences. The present research does not assume objectivity of the dimensions.

1.3 Diversity challenges at work

Managing a diverse workforce is one of the challenges that managers and leaders face in contemporary organisations. When this challenge is not effectively managed, negative outcomes occur (Hansen and Brooks, 1994; Mor Barak, 2011). Migrants form part of contemporary workplace diversities, presenting opportunities and challenges (Oerlemans and Peeters, 2008). On the positive side, workplace diversity provides opportunities for diverse skills, ideas, approaches, and perspectives in advancing organisational strategic goals (McLeod and Lobel, 1992; Watson, Johnson and Zgourides, 2002). In a study comparing performances, McCleod et al (1996) reported that performance of diverse groups was not only high but also qualitative in terms of output than non-diverse group. However, diversities in workplaces have also been found to breed interactional and relational conflicts (Ely and Thomas, 2001; Mcleod and Lobel, 1992), as a result of differences in values and preferences in expectations impacting relationships and other work-related outcomes (Cohen-Charash and Spector, 2001; Morrison, 1992; Thomas and Ely, 1996; Thomas, Kevin and Ravlin, 2003; Yamaguchi, 1994).

Ronen and Shankar (1985) found that differences in values, especially cultural conceptions, influenced employee needs, expectations, and work goals. Cultural values are among the influential factors in shaping diversities and identities in organisations and social settings (Earley, Ang and Tan, 2006; Thomas and Ely, 1996). It is argued that such values impact perceptions of structures and processes of the organisation, including involvement in decision-making processes and a sense of inclusivity or not within the system (Fischer and Smith, 2006; Markus and Kitayama, 1991; Mor Barak, 2005; Mor Barak and Cherin, 1998; Thompson and Rosch, 1999; Thomas, Kevin and Ravlin, 2003; Ronen and Shenkar, 1985). Organisations are power-driven social environments, therefore differences in perceptions increase the chances of inter-relational tensions among members. Minority groups with unique values and cultural conceptions may develop subjective feelings of exclusion from mainstream processes (Hitlan, Clifton and Desoto, 2006). This could lead to hostile feelings and interactional misunderstanding (Mor Barak and Cherin, 1998; Pettigrew and Tropp, 2006), affecting job satisfaction levels, organisation-based self-esteem, general well-being, and lowered expectations of employees (Ely and Thomas, 2001; Milliken and Martins, 1996).

Socio-cultural conceptions have been noted in research (Babatunde-Sowole, Jackson, Davidson, and Power, 2015) to impact on how employees establish their identity and their

senses of belonging within an organisation, hence the ever-present group dynamics in organisations. Studies (Fischer and Smith, 2006; Markus and Kitayama, 1991; Thomas, Kevin and Ravlin, 2003) of intergroup dynamics suggest that, with differences in values, interests and expectations, individuals may react negatively to actions and behaviours of others during interactions and socialisation at work. With intergroup dynamics, the perception of isolation and exclusion by a dominant group of a minority group can lead to negative feelings. Such perceptions can affect commitment and subsequently the quality of care these groups give in care and hospital environments (Bourgeault, Atanackovic, LeBrun, Parpia, Rashid and Winkup, 2009). Further to the above diversity management issues, Janssens and Zanoni (2014) in their study of alternative diversity management, found and suggested management practices that broaden competences and cultural identities to avoid social stigmatisation.

1.4 Intergroup relations at work

Cultural values as sets of ingrained schemas serve as building blocks from which information is processed (Thomas and Ely, 1996). An individual's perceptions of self and others guide the sense-making processes of events, actions, and behaviours in intercultural interactions (Bolten, 1999; Cohen-Charash and Spector, 2001; Erez and Earley, 1993; Fiske and Taylor, 1994; Gelfand, Erez and Aycan, 2007; Markus and Kitayama, 1991; Möller, 2010; Gelfand, Erez and Aycan, 2007; Tsui, Nifadkar and Ou, 2007).

In their study of interactive acculturation and intergroup relations within multicultural workplaces, Oerlemans and Peeters (2009) found that poor intergroup relationships among Dutch and their non-Western colleagues at work led to feelings of exclusion and intergroup tensions. If employees misunderstand cultural assumptions of other groups in the workforce, it leads to poor intergroup relationships, affecting their work performance. (Thomas and Ely, 1996; Thomas, Kevin and Ravlin, 2003; Yamaguchi, 1994). The appreciation of ethnic diversity issues in organisations is therefore important because it improves operational effectiveness, especially in negotiation, equitable reward systems, facilitation of communication and adoption of appropriate leadership styles (Hansen and Brooks, 1994; Hofstede, 1980; Graham, Mintu and Rodgers, 1994; Kim, Park, Hun-Joon and Suzuki, 1990; Vemar and Becker, 1975). It is also the foundation to minimise risks and improve collaboration among diverse organisational players (Jackson, Joshi and Erhardt, 2003; Matic, 2008; McAllister, 1995).

While there has been progress in research on aspects of organisational diversity, research on differences in cultural values and their implications for employee perceptions of experiences has been sparse (Ogbonna and Harris, 2006). Consequently, many people have called for detailed exploration of ethnic values, perceptions, responses, and outcomes in organisations (Allan and Larsen, 2003; Oerlemans and Peeters, 2008; Ogbonna and Harris, 2006; William and O'Reilly, 1998).

1.5 Research sample and location

Data for this research was collected from a purposive sample of fifteen (N-15) West African migrant nurses working in independent nursing homes in the South East of England, including London. Participants were recruited using set inclusion criteria. The choice of the South East of England, including London, was a result of the high number of migrant nurses and the high number of nursing homes in the area (Buchan, 2003). The South East of England includes the following counties: East Sussex, Hampshire, Kent, West Sussex, the Isle of Wight, Oxfordshire, Surrey, Berkshire, and Buckinghamshire. According to the Office of National Statistics figures for the 2001-2011 censuses (www.ons.gov.uk) the South East of England has the highest proportion of residents in nursing and care homes across England and Wales. Geriatric statistics suggest a high growth rate within the elderly population. There is a projection that the number of 75-year-olds and above will rise from seven hundred and ninety thousand to over a million between 2015 and 2037 (www.secouncils.gov.uk).

1.6 Research objectives (ROs)

In the context of the above research background, the research has the following objectives:

- *To extend understanding of expectations and experiences of West African migrant nurses in the United Kingdom*
- *To offer insight into the emotional and behavioural responses of West African migrant nurses to their perceptions of experiences at work in the United Kingdom.*

To explore expectations and perceptions of experiences of West Africa migrant nurses in the United Kingdom, the researcher examined their perceptions of their interactions and relationships with their British-born managers and work colleagues. In doing this, the

researcher took a broad approach to understanding relationships and social exchanges in exploring the role of culture in the nurses' perceptions of breached expectations from a qualitative perspective.

1.7 Research methodology and design

This is qualitative research with a two-study design. The research is based on data collected in two phases through semi-structured interviews in two separate interview sessions.

The first study explored West Africa migrant nurses' reasons for migrating to the United Kingdom and their expectations of the experience while the second examined the role of culture in the nurses' perceptions of their experiences as well as their management of conflicts of expectations and experiences. Both studies were aimed to create deeper insights and extend understanding of the nurses' expectations and experiences at work in the United Kingdom.

In exploring both aspects of the research, qualitative research was employed to explore the phenomena involving expectations, perceptions, and experiences (Creswell, 2003). The researcher relied on the interpretive ontology, which considers knowledge as depending on interpretations to evolve meanings (Hatch, 1997; Walsham, 1995). In evolving meanings and understandings of what the nurses' experiences mean to them, the researcher employed template analysis and the interpretative phenomenological analysis for Studies One and Two, respectively.

1.8 Significance, originality, and contribution

The overarching purpose of this research is to understand the expectations and perceptions of experiences of West African migrant nurses in the United Kingdom. The researcher adopted an exploratory approach to explicate the complex nature of expectations, interaction experiences and cultural issues. While the present research is a follow-up to previous research suggestions on migrant nurses' general experiences in the United Kingdom, it is distinctively significant because it provides a deeper insight into understanding expectations and perceptions of experiences at work of migrant nurses, specifically West African migrant nurses. It seeks to make contributions through empirically evolved insights into how management can support migrant nurses to fit into work as organisational insiders (Tharenou and Kulik, 2020) and enhance their wellbeing at work. In their previous separate studies, Bakewell, and De Hass

(2007) as well as Okeke-Ihejirika, Salami and Ahmed (2018) reported that there have been misconceptions of the factors that motivate and encourage African professionals to migrate to other countries. The present research makes an empirical contribution in understanding of the motivation, expectations, and perceptions of experiences of West African nurses for both theoretical and practical purposes.

This research, therefore, adds to the scanty literature and provides an overall insight into the expectations, experiences, and emotional and behavioural responses of migrant nurses, especially West Africa migrant nurses at work. Given suggestions (Aju and Beddewela, 2020; Babatunde-Sowole, Jackson, Davidson, and Power, 2016; Ogunsiyi, Wilkes, Jackson, and Peters, 2012) of lack of clarity on practical management approaches on appreciating migrant nurses' values and experiences, the outcomes of this research provide insight for organisations to target interventions and appropriate support for migrant nurses and employees.

1.9 Structure of the thesis

This thesis is structured under ten separate chapters, excluding the introductory chapter.

Chapter 2: This chapter is the first part of the review of relevant literature for the research. It examined theories of international migration, categories of migrants and African professionals' migration patterns to countries of the West.

Chapters 3 and 4: These chapters formed the second part of the review of relevant literatures on exchange relationship theories and construct of psychological contract as understood through the organisational justice framework as well as the leader member exchange theory (Lmx) and differentiation. The chapters also introduced the concepts of perceptions and culture. The chapters also contain the review of Africa's indigenous traditions and values which complemented the literature on applied cultural values for the research.

Chapter 5: The chapter contains the overview of the research methodology and design. The epistemological and ontological underpinnings of the research were explained. This chapter also contains the researcher's choice of method of data collection as well as the processes used in the recruitment of participants for the research.

Chapter 6: This chapter introduces the process and outcomes of study one. This study examined the reasons West African nurses use to explain their migration to the UK. The chapter provided insights on the reasons and expectations of the nurses on their migration to the UK. It also contains the linking section that explained the understanding between study one and study two of the research in relation to expectations and perceptions of experiences.

Chapter 7: This chapter introduces the process and outcomes of study two of the research. This chapter introduces the interpretative phenomenological analysis as the technique of analysis for study two. The chapter highlighted the process of the analysis technique and the generation of both descriptive and superordinate themes from the study.

Chapter 8: This chapter outlined the findings of study two which answered research questions 2&3. The chapter contains the various themes as generated and used to answer both questions.

Chapter 9: This chapter contains the researcher's discussion on the aggregate findings of research questions 1,2 & 3. This chapter contains insights generated on the nurses' reasons, expectations, and experiences at work in the United Kingdom. The researcher, in this chapter articulated the overall themes of the research from both studies one and two.

Chapter 10: This chapter contains the conclusions as drawn based on the findings. It also contains suggestions put forward for future research. It also contains the summary on the contributions of the research to both knowledge and practice. This chapter also discussed the limitations of the research.

1.10 Framework of Studies One and Two

In **Study One**, the researcher explored the following question: *(1) What reasons and expectations do West African nurses use to explain their migration to the UK?* In **Study Two**, the researcher explored the following questions: *(2) How might cultural conceptions explain West African migrant nurses' perceptions of experiences at work in the United Kingdom? (3) How do West African migrant nurses manage conflicts between their expectations and experiences at work.*

Figure (1:1)below shows the diagrammatic details of the processes which the researcher used in Study One and Study Two. The arrows show how the research questions lead to the methods, analysis and findings for the next study and the overall findings and recommendations of the research.

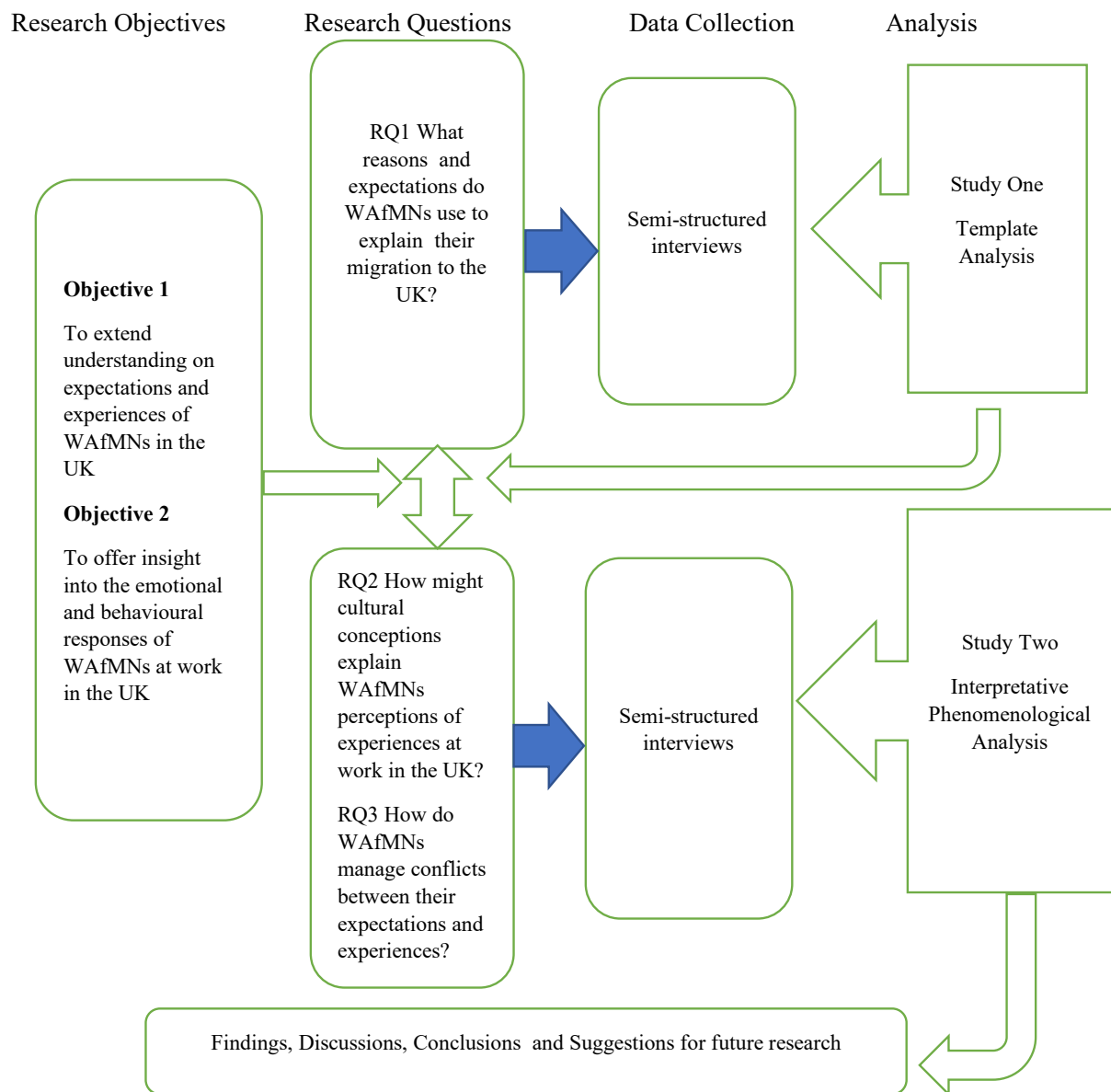


Fig 1.1: Research framework showing processes of Studies One and Two

Chapter 2: Literature Review (1)

2.1 International migration and migrants' experiences

This is the first of two chapters reviewing the literature on theories and empirical studies of relevant concepts to position the present research (Bloomberg and Volpe, 2008). The first chapter reviews concepts of international migration, migrant nurses in the United Kingdom and their experiences. The second chapter of the literature review focuses on theoretical underpinnings of the research.

2.1.1 The neoclassic economic migration theory

According to the United Nations department of economic and social affairs, international migration as a global phenomenon has grown in scope, complexity, and impact (www.undp.org). The classic understanding of migration as a phenomenon is associated with its historical theories of push and pull factors that are assumed to drive the urge for people to move from their original location to other places to live, work or both (Djukic, Kovner, Budin and Norman, 2010; Lee, 1966).

The theory of international migration from a neoclassical economics perspective is based on assumptions about migrants' expectations of financial and material earnings. Migrants' decisions to move from source to destination country is argued to be dependent on their calculations in comparative terms of benefits in wages and earnings between source and destination countries (Borjas, 1994; Castle & Miller, 1998; Massey and Espinosa, 1997; Todaro and Maruszko, 1987). In a longitudinal survey that explored the residential trajectories of young immigrants to the United States, Reagan, and Olsen (2000) found that economic incentives and welfare opportunities constituted basic attractions and incentives for immigrants. This perspective is understood from the point of view of investment, which explains why family members of prospective migrants' pool resources together to support the process with potential migrants as actors in processes leading to a potential change of economic fortunes (Massey, Arango, Hugo, Kouaouci, Pellegrino and Taylor, 1988; Todaro & Maruszko, 1987).

According to De Haas (2010), increased earnings in destination countries, in addition to supporting household incomes, also augment national economies. In any migration move, involving jobs, Geist, and McManus (2012) argue that household incomes and earnings are increased. Some national governments have policies which support the migration plans of their citizens. This emergence of state actors in migration discussions and considerations is a new phenomenon with politics and governance being associated with migration decisions (Solimano, 2005).

In their study, Aiken, Buchan, Sochalski, Nichols and Powel (2004) report finding that countries like the Philippines adopt a state policy of training and exporting their nurses for higher earnings, portions of which are remitted back to add to their gross domestic product (GDP). The migration observatory unit of the University of Oxford estimated that black Africans in Western countries remitted huge funds to their home countries in 2014 (www.migrationobservatory.ox.ac.uk).

2.1.2 The international labour market migration theory

According to international labour theory, the disparity between the labour needs of the industrialised world and developing countries is significant. With high per capita income associated with high socio–developmental needs, developed Western countries are constantly under pressure to meet their labour needs consistent with their development paces.

According to migration scholars, socio-development needs in relation to labour needs serve as strong attracting forces for international labour and migrants (Dickens and Lang, 1985; Piore, 1979). In developed economies, high employment vacancies in both high-skilled and low-skilled sectors form a strong attraction for prospective migrants from developing or less developed nations (Portes and Bach, 1985; Taylor, 1992).

However, in a documentary review of the emigration of medical doctors from the United Kingdom to Canada between 1955 and 1975, Wright, Mullaly and Cordukes (2010) found that pull factor expectations of career progression, better practice environment and specialist training opportunities available in Canada at the time formed strong reasons for the medical professionals' migration. This suggests that the rate of development may not determine the flow of migration in some circumstances regarding migrants' expectations of filling jobs in

those countries. A similar finding was highlighted in a study by Clarke, Crowe, Humphries, Conry, O'Hare, Kavanagh and Brugh (2017), which argued that Irish healthcare professionals migrated to other countries because of better training facilities in those countries. This further suggests that there is no absolute correlation between a country's rate of development and a high rate of migration of its citizens (Belloc, 2011). On the contrary, development that correlates with high income, improved living standards and citizens' ability to meet migration costs could increase the rate of migration. The above position could, however, depend on the nature and pattern of the movement under the circumstances described. The mobility of individuals from such developed economies could be for general reasons of education and business opportunities because of the availability of resources to do so.

2.1.3 Deciding to migrate

International migrants' ability to translate intentions into actions is positively related to the amount and levels of risk aversion and fear of failure that intending migrants are ready to tolerate. International migrants are exposed to uncertainties of a new environment that could impact their health, loneliness, and other socio-emotional factors (Ogunsiji, Wilkes, Jackson, and Peters, 2012). As a phenomenal change process, international migration decisions rest on considerations of the unknown and its uncertainties.

In anticipation of possible risks and uncertainties, migration decisions are sometimes made using support systems, including social networks and contacts to help with plans. Potential migrants rely on information that tends to mitigate possible feelings of apprehension of the unknown to determine whether they would embark on their plans or not (De Haas, 2010; Drinkwater, 2002; Massey and Espinosa, 1997; Papapanagos and Sanfey, 2001).

Migrants benefit from the support of peers and family members in relation to monetary assistance and anticipated logistics in destination countries, which reinforces motivation (Davis, Stecklov and Winters, 2002; Davis and Winters, 2001; Massey, Goldring and Durand, 1994; Massey, Arango, Hugo, Kouaouci, Pellegrino, and Taylor, 1993). Research suggests that potential migrants consider destinations where there are already contacts with family members, friends and/or group affiliations. In the 1990s, a considerable number of African migrants to the United States were close relatives of African American citizens (Hatton and Williamson, 2003). According to Healy and Oikelome (2007), whose study relates to underlying factors that

encourage migration to the west found that previous political and social ties with developed countries of the west encourage migration from developing nations of the south.

2.1.4 Categorisation of migrants

International migrants are categorised according to the circumstances of their movements, hence the categories of forced and voluntary migrations. The two categories are based on the natural circumstances and direction of international migration, especially of people from developing nations of the South to developed economies and industrialised nations of the West.

2.1.4.1 Forced migrants

Forced forms of migration are categorised as involving migrants that move from their original location because of political and social breakdowns. Political and social upheavals in geopolitical regions can force people to react to the prospects of seeking safe havens as refugees and asylum-seekers (Davenport, Moore, and Poe, 2003; Morrison and May, 1994; Moore and Shellman, 2006; Wickramaasekara, 2008). In a study, Shellman and Stewart (2007) found that Haitians migrated to the United States following intense political infighting and internal strife in their home. This was an inevitable move to safe havens to avoid being victims of the violent situation.

When man-made conflicts and natural disasters occur in a region, there are no choices and fewer options for the people caught up in them. A classic case of this circumstance was in the report of Nicaraguans mass migration to the United States as a result of armed conflicts in the country (Alvarado and Massey, 2010). Experiences of forced migrants are likely to differ from voluntary migrants because the former are in most cases pushed rather than pulled into the migration processes, with limited or no planning and preparations for the movement (Akinsulure-Smith and O'Hara, 2012).

2.1.4.2 Voluntary migrants

In contrast to the forced form of migration, voluntary migrants' decisions are based on choice. In a study of forced and voluntary migrations, Disbudak and Purkis (2016) suggest that voluntary migrants intend to make a return migration. This means that voluntary migrants

consider their movement as temporary, with intentions to return to their home countries or advance to different destinations of choice later.

However, in a study on the effects of gender, migration and social change on Filipino women migrants, Sri Tharan (2010) found that the motivation for return migration for voluntary migrants was only considered when pre-migration expectations seemed to be met or there were strong feelings of long absence from home. This suggests there is the possibility of migrants overstaying their anticipated plan to return home if initial expectations have not been met.

Section summary: The immediate sub-section of the thesis highlighted the nature of international migration. The generic theories that support reasons and motivation for people to move from one part of the globe to another were identified. The push and pull factors depending on the circumstances of the potential migrant, location, and expected destination. Fundamentally, while decisions to migrate could be voluntary, circumstances could inform decisions to move from one location to another under conditions of extreme necessities.

While Aiken, Buchan, Sochalski, Nichols and Powel (2004) and Kline (2003) reported paucity of data on the dynamics of Africa migration to western countries of Europe and America, some studies (Aboderin, 2007; Salami, Dada and Adelakin, 2016; Iheduru-Anderson and Wahi, 2018) focused on specific contexts of migration and globalisation, implications of the nurses' migration on health of source countries, and nurses' migration to the USA, respectively. However, the present researcher's search, using key words 'West African+ nurses', 'Nurses + expectations', 'Migrants + nurses', on academic databases; 'ABI/INFORM', 'Academic Search Complete', 'Directory of Open Access Journals' and 'Google scholar', showed no research specific on international migration of West African nurses, their expectations and experiences in the United Kingdom as conceived in present research.

2.2 African international migration patterns

In this sub-section of the chapter, the researcher reviews what is known through research on the pattern of generic African migration, including nurses and other professionals to industrialised nations of the West.

African migrants are among the fastest-growing migrant populations in Western countries, including the USA and UK (Thomas, 2011; Kent, 2007). While there have been anecdotal accounts of the general migration patterns, motivation, and experiences of African professionals' migration to the West, there is patchy empirical data on West Africa migrant nurses' (Aiken, Buchan, Sochalski, Nichols and Powel, 2004; Dovlo, 2007). However, a World Bank report, (Parson, Skeldon, Walmsley and Winters, 2007) suggest that African countries contribute at least eight percent of international migration to western Europe, many of whom are professional healthcare workers, including doctors and nurses (Aiken, Buchan, Sochalski, Nichols and Powel, 2004).

2.2.1 Socio-economic well-being of the people

Studies carried out on sub-Saharan African migration suggest that a high proportion of about 65000 African trained physicians and 70000 Africa born professional nurses have migrated to the West (Awases, Gbary, Nyoni and Chatora, 2004). According to Alan and Larsen (2003), three main aims, the desire to improve learning, practice skills and acquire knowledge in destination countries, provide the push and pull motives for healthcare and nurses migration, especially from developing countries to developed nations, including the United Kingdom. The study also noted that apart from expectations of benefits of high standards of nursing practices, nurses from developing nations also aim to achieve financial and material gains to enhance their poor socio-economic conditions.

For these migrants, the Western countries provide opportunities for a better quality of life, pay and working conditions, along with improved clinical facilities that enhance training opportunities, and personal safety. Research (Saxenian, 2010; Tynaliyev and McLean, 2011) maintains that acquiring new skills from destination countries remains one of the many outcomes of migration. As migrants go outside their countries of origin, the tendency to imbibe new practices and standard ways of doing things are found to be attractive in their countries of

sojourn. As a natural tendency, most migrants anticipate life in the future, and so acquisition of material and intellectual resources becomes one of the common reasons for international migration.

Another consideration on decisions to migrate was found in the understanding that migrants earnings contribute to poverty reduction and improved standard of living in home countries (Patterson, 2006; Portes, Escobar and Radford, 2007). Asiedu (2005) suggests that diaspora remittances increased private sector investment in real estates for housing and entrepreneurial projects when compared to public sector investments in Africa (Asiedu, 2005). This indicates that remittances from citizens abroad cause private sector investment in housing to outstrip public sector investment, hence African governments' campaigns and calls for continuous partnerships with its diaspora citizens in housing and other developmental projects in Africa. While it has been suggested that migrants' remittances support capital infrastructural developments and income-generating activities (Tynaliyev and McLean, 2011) in home countries, it has also been argued that the claims that migrant remittances, especially to developing countries, do not add much to the infrastructure development of such countries because much of the remittance goes into direct family consumption and welfare.

In a survey on living standards in Ghana, Litchfield, and Waddington (2003) found a positive correlation between domestic household welfare and migration. Families whose members migrated abroad were observed to have higher living standards than those families with no members abroad (Cattaneo, 2009). In a society where everyone is each other's "brother's keeper," migrant remittances back home to support families are not only a financial but equally a moral obligation (Humphries, Brugha, and McGee, 2009).

The moral mindset of financial responsibilities of relatives abroad for families back home could lead to migrants' feelings of emotional guilt if these are not met (Babatunde-Sowole, Jackson, Davidson, and Power, 2016; Oyeyemi and Sedenu, 2010). However, Yeates (2010) observed that migrant nurses' expectations of higher wages with the potential for a higher standard of living and opportunities for improved professional development served as strong motives for immigration of the nurses to the West.

2.2.2 Poor leadership and governance

Making a case for socio-political dimensions to migration Aboderin (2007) and Adepoju (2003) suggest that the long history of economic deterioration of most of the countries in Africa contributes substantially to reasons for migration. Deplorable leadership and governance culture in most African countries after political independence has had great negative impact not only on basic development infrastructures but also on the general well-being of the people. The consequences of these situations is manifested in prolonged economic stagnation, political instability, and low standards of living in Nigeria (Aboderin, 2007 ; Adepoju, 1998; Fajana, 2008).

The Nigeria case was not isolated because several other African countries, particularly those in the Sub-Sahara (Ghana, Sierra Leone, Guinea, Ivory Coast, Togo, Gambia, and Niger Burkina Faso.) severally experienced military dictatorship for several years. The general consequences of these situations included deplorable infrastructure and poor human rights records that eroded investor confidence, decreasing investments from both foreign and local investors. In a study which examined the reasons forcing West African migration, Kirwin and Anderson (2018) reported that, contrary to assumptions that economic factors drive migration in West Africa, people's perception of the decadent democratic institutions were found to be fundamental. This suggests why even young, educated professionals who are already in well paid jobs are more likely to take options of migrating abroad; they are concerned that the system cannot guarantee their security and wellbeing. In a similar study on the influence of return migrants on socio-political changes, Tuccio, Wahba and Hamdouch (2019) reported evidence to suggest that individuals who have sojourned abroad as migrants are more likely to influence positive political changes in their countries.

The discovery of mineral resources in most of these countries diverted attention from the traditional and sustainable bases of the economies of most African countries, mainly agricultural. With dependence on mined resources such as oil and diamonds and the consequences of their erratic global supplies and pricing, projected revenues and public sector investment in social infrastructures became affected. With such social, economic, and

structural uncertainties, mass migration of professionals including nurses and doctors to countries of the West became inevitable.

2.2.3 Pressures from families

In severe periods of economic uncertainty, families came to rely on mobility strategies, including migration economic benefits to survive and mitigate household situations. A World Health Organisation report (WHO, 2004) states that about sixty five percent of interviewed Africa healthcare professionals considered leaving to work in Europe or the USA because of their family's poor economic conditions. The nursing profession was historically considered a feminine career in some societies, including Sub-Saharan Africa. It was not regarded as socially within the middle or upper class of mainstream careers. However, this perception has reversed over time with nursing becoming not only a career with great economic potential but also a status symbol. African nurses add value to their families' material well-being and demand for their services is on the increase both in home countries and abroad, providing opportunities of choice for the practitioners (Adepoju, 2004; Obioma, 2014). The extended family systems in Africa put pressures on average professionals such as nurses who are expected to cater for all.

2.2.4 Attractions from western countries

The lure of the attractive employment packages is too tempting in monetary value to be ignored by most of these professional health workers, including nurses. Attractive conditions inform the pull from countries such as Canada, the United States, Ireland, and the United Kingdom (Odoemene and Osuji, 2015).

One of the reasons adduced for the nurses' migration rush to rich Western countries such as the United Kingdom is the relative ease of communication and lifestyle. In a study on the migration of health professional from Africa to rich Western countries, Hagopian, Ofusu, Fatusi, Biritwum, Essel, Hart and Watts (2005) noted that the attraction of Western countries for these professionals is usually built up even during their training days when their lecturers who either studied or lived in these Western countries paint rosy pictures for them of the lifestyles and training facilities that abound in Western countries. In the case of the United Kingdom, migrants found the English language to be a tool for easy integration, especially with historical and political ties as former British colonies.

Section summary: The above sub-section reviewed patterns of migration from Africa to countries of the West. While the review did not capture specifically African migrant nurses' patterns and reasons for migration, it did provide a bit of an understanding of a general nature involving all categories of migrants from the continent of Africa. It is to be noted that, while the review highlighted reasons for their migration, not much was captured on their experiences at destination countries as reviewed. The reasons provided information about African migrants and added to our understanding of the push and pull factors for African migrants. However, some of the previous research findings highlighted factors which were time framed. For instance, almost all the nation states that make up Africa are now under democratic governments, away from previous military dictatorships and regimes. The review therefore revealed gaps that given findings in research, investigations into West African nurses' migration may reveal further issues which may be particularly important to them and to all other migrant workers.

In the following sub-section, the researcher reviews the United Kingdom's need for migrant nurses and the reasons that the country continues to rely on these nurses for its health and social care services. It also positions the present research toward understanding why nurse migration from Africa to the United Kingdom continues to increase despite bilateral and multilateral governmental agreements between African countries and the United Kingdom to discourage such a surge of nurses from developing countries, given Africa's critical health sector and manpower needs.

2.3 United Kingdom: The need for migrant nurses

Gaps in funding and projected funding put pressure on the development of local manpower capacity, which invariably has consequences for the care of the country's aging population (Hancock, Wittenberg, and Hu, 2013).

2.3.1 Geriatric statistics

Most Western countries, including the United Kingdom, rely on international migrant nurses to make up for staff shortages in the health and social care sectors because of ever-increasing demand for skilled nurses and the decreasing new entrants from the local labour force (Buchan, 1999). The United Kingdom's health and social care sectors face chronic manpower needs,

with an aging workforce and increasing need for the nursing care of aging population (Beishon, Virdee and Hagel, 1995; Buchan, 2001; Yeates, 2010).

The Care Quality Commission (CQC) reports that the trends in care involving family members who are usually not paid declined between 1997 and 2006. An estimated two million family members withdrew their care services to their members within the period. (www.cqc.org.uk). An increase in the need for geriatric care because of increased life expectancy has not been matched by increased trained care and nursing staff. The current statistics suggest that the population of people aged 65 years and over in England will increase by sixty-five percent, from 8.2 million to 13.4 million over time (Wittenberg, King, Malley, Pickard, and Comas-Herrera, 2010).

These projections are based on the increase in the number of elderly citizens in the United Kingdom of 80 years and above by over seventy percent between 1981 and 2006 with a further increase projected between 2006 and 2031 from 2.7 million to 5.4 million. This situation is projected to lead to excess manpower demand for the care of the elderly, a demand which could only be met through international manpower resourcing (Ball and Pike, 2004; Cangiano, Shutes, Spencer and Leeson 2009; Pickard, 2008; Warner, 1999). There is higher number of migrant nurses in nursing and residential care homes in the United Kingdom (Ball and Pike, 2007).

2.3.2 Shortages of indigenous trained nurses

This is also affected by the cost of training a local nurse (Buchan and Seccombe, 2006) when compared to the cost of hiring overseas nurses as quick fixes. Similarly, there is a high rate of dropouts in training among British natives, which is attributed to the lack of attraction that nursing offers, hence the high local nurse attritions especially in independent nursing homes (Hardill and Macdonald, 2000; Meadows, Levenson and Baeza, 2000; Munro, 1999). The situation continues to sustain the drive for the continuous recruitment of social and health care workers from abroad as the only viable option for the industrialised world, including the United Kingdom to keep pace with staffing needs (Husband, 1985).

2.4 United Kingdom: Nursing and care home structures

In the following subsection, the researcher reviews the regulatory structures of the nursing homes from which the current research participants were recruited. The researcher also reviews training and knowledge development requirements and standards required within the independent nursing home sector in the United Kingdom. The researcher also reviews the processes of adapting migrant nurses into practice proficiencies in the United Kingdom.

West African migrant nurses registered to practice and work in the United Kingdom can work within the National Health Service (NHS), which is publicly funded. However, they are largely employed by independent nursing homes, which are run by private organisations with profit-making business models. The home care system in the United Kingdom is made up of residential, nursing, and young adult care homes. Residential and nursing homes in the United Kingdom are for elderly people who live their lives independent of much assistance. However, they may need some levels of assistance to carry on with daily living. In addition to those needs, some of the residents do need clinical support and assistance that only trained and registered nurses would offer. There are also provisions for younger adults who need care because of some form of disability. All three categories are classified as care homes (www.cqc.org.uk).

2.4.1 United Kingdom: Registrations of nursing and care homes

In the United Kingdom, the Registered Homes Act (1984) provides regulatory and inspection framework guidelines for all existing and prospective new care and nursing homes. Nursing and care regulatory bodies ensure the attainment of national minimum standards for all the homes (www.nursingtimes.net). A prospective nursing or residential home, as stated in the Health and Social Care Act 2008 (Regulated Activities), is required to recruit, and deploy an adequate number of trained employees, including nurses, at any given time. The current central regulator of both nursing and residential homes in England is the Care Quality Commission (CQC) (Fitzpatrick and Chang, 2015; www.rcn.org.uk).

All employees of nursing and care homes in the United Kingdom, including nurses, as a matter of regulatory guidelines and policy guidelines, are expected to be on continuous training, supervising and appraisal processes. These are necessary to equip them with the relevant skills

and knowledge refreshers to do their jobs efficiently and effectively. Migrant nurses as classified are expected to adapt to the system and processes in their practices within the health and social care sectors.

2.4.2 United Kingdom: Migrant nurses' adaptation and admission

The United Kingdom's nursing regulatory body, the Nursing and Midwifery Council (NMC) expects necessary competences to be met by every potential nurse registrant in the UK. These competencies include understanding professional values, achieving the desired communication and interpersonal relations skills, nursing practice and decision-making skills, as well as leadership, management and team working competencies. (www.nmc.org.uk).

The pre-entry training process explains that training and retraining of nurses remain among the most cardinal objectives for all nurse registrants including migrant nurses to maintain practice and to advance in their careers. The Nursing and Midwifery Council (NMC) carries out the initial assessment of the migrant nurses' overseas qualifications and training against the standards in the United Kingdom and in line with the Nursing and Midwifery Order, 2001, and the Charities Act, 1993 (www.nmc.org.uk).

All fifteen (n=15) West African migrant nurses who participated in this research followed the set processes of revalidation after migration to be formally admitted into the Nursing and Midwifery (NMC) register to practice. This initial process involves the potential migrant nurse's providing evidence of a pass of the International English Language Testing System (IELTS) L7 in reading, writing, speaking, and listening. According to Winkelman-Gleed (2006), most migrant nurses in the United Kingdom are voluntary migrants who followed a standard process of adaptation and registration that qualifies overseas nurses to practice nursing in the United Kingdom National Health Service (NHS) or the Independent Health Sector (Nursing and Care Homes).

Section summary: This sub-section reviewed the United Kingdom's inevitable need for migrant nurses, essentially because of its health and social manpower needs. It identified the fact that, within nursing care homes, there is a lower percentage of native British nurses. This informed the high percentage of migrant nurses within this sector. Even though there is no clear reason why this is so, the literature suggests that nursing as a profession is less attractive to the

natives. This is evidenced by high dropout rates in the training of native British student nurses as documented.

The sub-section also reviewed the structure and regulation of nursing homes in the United Kingdom. All fifteen (n-15) West African migrant nurse participants in this research work in nursing homes. The section also identified the regulatory requirements for training and refreshers for all employees, including nurses, to keep up with the knowledge and skills needed to do their jobs.

2.5 United Kingdom: Background of migrant nurses' experience

In this sub-section, the researcher examines literature and previous research on the experiences of migrant nurses in the United Kingdom. This review is fundamentally important to understand what is going on and to identify gaps and reposition the present research. In this research, migrant nurses are identified similarly with other terms and are used interchangeably through the thesis. These include overseas-trained nurses (OTNs), internationally educated nurses (IENs), internationally recruited nurses (IRNs), internationally qualified nurses (IQNs).

Nursing as a form of the care profession in the United Kingdom were previously dominated by women and often women of colour was undervalued and under paid (England, 2005; Smith and Mackintosh, 2007). The cognitive association framework of socio-economic devaluation was therefore used to pitch nursing, with its low social and pay status attachment, as only good for the feminine gender. However, going through the years in the United Kingdom, the historical narratives about nursing and nurses changed. Nurses are currently highly rated and sought after in most countries across the world where the demand for nurses surpasses the supply (Hardill and Macdonald, 2000). More men also currently identify with the profession of nursing, hence marking a paradigm shift in perception of nursing from being a vocation and care-work meant only for women to a scientifically qualifying profession across genders. Aboderin (2007) in her study of contexts, motives, and experiences of Nigerian overseas nurses, highlighted similar shifts of social perceptions of nursing from being a demeaning profession to more of a prestigious profession. Nurses in Africa earn respect and economic positions in their country due to the intellectual rigours of their training as well as good salaries as compared with other professions, which guarantees their elevated social statuses.

However, in Africa, the level of decadence in national governance has had its impact on general labour welfare, with reduced pay and other working conditions of nurses. The situation has contributed to many nurses and other healthcare professionals leaving their countries of origin to seek opportunities in western developed nations, including the United Kingdom. Smith and Macintosh (2007), however, note that migrant nurses in the United Kingdom continue to be classified with the cognitive association framework of the past. Migrant nurses are associated with ethnic minorities and consequently perceived as an undervalued class. In recent past, research involving migrant nurses have identified concerns which the present research classified into four themes as in the following review.

2.5.1 Disproportionate role assignments

Research and studies conducted in recent years in the United Kingdom on the experiences of migrant nurses suggest the nurses' reports of negative experiences from organisational structures and interactional issues at work. In a study using the qualitative focus group interview method, Alexis, Vydelingum and Robbin (2007) suggest that migrant nurses perceived that their skills are being consciously or unconsciously devalued at work. This was reported to be due to perceptions of lack of opportunities to apply their competences, high levels of control and less delegation of challenging responsibilities. Post their adaptation programme, majority of migrant nurses in the National Health Service (NHS) trusts were found to be within the basic "D" job grades, suggesting an environment of unfair practices (Smith, Allan, Henry, Larsen, and Mackintosh, 2006). An average sixty four percent of black and minority ethnic nurses are found in this grade, compared to thirty six percent of white British nurses (Pike and Ball, 2007). While details of the above statistic seem not to be comprehensive and clear, this perceived disproportionate employment grading suggests migrant nurses' career progression within the system is doubtful. While Henry (2007), in a study of institutionalised disadvantage and Ghanaian nurses' reflections on career progression and stagnation in the NHS, found little statistical evidence that migrant nurses in the United Kingdom are slower on the career ladder compared to their white UK trained counterparts, the study acknowledged limitations in the analysis of the nurses' exact experiences and issues that impacted on their career progressions.

According to O'Brien (2007), a case study of the experiences of international nurses in the northwest of England showed that overseas nurses were disadvantaged in using their skills and knowledge at work. Overseas nurses who participated in the study felt that allocating substandard roles to them undervalued their previous skills and knowledge from their previous training. For instance, there was a case where they were not allowed to manage procedures until undertaking specialise training, even though they understood and could manage these procedures from their original training in home countries. While the argument for retraining to ensure competency seems valid, migrant nurses felt procedurally disadvantaged in relation to getting places on the list for specialise training. Nichol and Campbell (2010), in their review of research on the experiences of migrant nurses, found the nurses' perceived that roles and responsibilities assigned to them at work were quite disproportionate to their skills and expertise. Perceptions of deliberate placement or assignment to inappropriate roles that are incongruent to skills and knowledge could put an emotional burden and psychological strains on migrant nurses (Rosenkoetter, Nardi and Bowcutt, 2017).

Adhikari and Melia (2015) used a multi-sited ethnographic approach to examine experiences of migrant nurses of Nepali origin working in the United Kingdom and found that even though they are highly qualified and experienced professionals, their assignments to disproportionate roles led to feelings of deskilling which impacted their competency self-esteem. This study reported the nurses' downward spiral of feelings over job satisfaction as a result.

The nurses' feelings of devaluation of skills and competencies have been linked further to their limited access to specialised training on modern clinical procedures (O'Brien, 2007). However, when considered differently, access to modern nursing and or clinical procedures could be argued to be much more possible in mainstream hospital facilities. According to Aiken, Buchan, Sochalski, Nichols and Powell (2004), independent nursing homes in the United Kingdom employ a high number of migrant nurses on average, with about sixty percent of their nurses being migrants and overseas-trained nurses. While it is not clear yet, the reason or reasons for the high number of migrant nurses in nursing and care homes in the UK (Likupe, 2006; Withers and Snowball, 2003), there is not much need for clinical equipment because clinical procedures that require such equipment are not as common in nursing homes as in mainstream hospitals (Baxter, 1988; Buchan and Seccombe, 2006).

2.5.2 Micromanagement and control

Migrant nurses' feelings that their skills and knowledge are devalued are linked to their perceptions of close monitoring, constant supervision, and micromanagement at work. A study by Likupe (2013) of black Africa nurses' experiences in four NHS trusts suggested that migrant nurses work within controlling environments. The nurses consider this as a deliberate attempt to undermine their previous training and experiences. Migrant nurses reported the lack of reasonable freedom, independence, and discretion, which enable employees to determine task processes. With the impact on the nurses' well-being, further perceived doubts about their competences were reported to affect their effective engagement at work.

Self-determination theory (SDT) suggests that an individual's belief in his or her own ability to get the right organisation of the work process for positive work outcomes is effective because of its association with motivation and wellbeing (Gist, 1989; Lathan and Trayne, 1989). Karasek (1979) suggest that employees who are denied opportunities for some degree of judgment in carrying out tasks for outcomes experience psychological strains. Alternatively, the recognition of an individual's skills and competences, trust in those abilities, and opportunities to apply right courses of action to achieve desired outcomes enhance feelings of psychological empowerment of self-esteem and translates into job satisfaction. This has been correlated with positive behavioural outcomes of organisational citizenship' behaviours (Bandura, 1997; Bandura, 1986; Conger and Kanungo, 1988; Gist and Mitchel, 1992; Locke, 1997).

While control relations in organisations could be a coordinating mechanism that serves to ensure that work and employees are organised for appropriate practices toward achieving organisational requirements, this can be achieved without being embedded in institutionalised power-driven structures (Reed, 2011). This in effect suggests that control relations that involve participation through lateral decision making and sharing of influences could be productive when conducted within the right processes. However, control could be counterproductive when applied and viewed within and through the framework of hierarchical power structures, interests, and value protection. This, as argued, could lead to protective and defensive behaviours that parties involved project to influence processes to their advantage (Wagner, 1994).

2.5.3. Transparency issues

In a survey study that examined racial harassment, job satisfaction and intentions to quit among nurses in Britain, Shields, and Price (2002) found that international migrant nurses, especially black Africans, felt discriminated against at work regarding promotions and training opportunities. In a commissioned study on the experiences of international migrant nurses, Smith, Allan, Henry, Larsen, and Mackintosh (2006) reported deliberate cases of lack of transparency in promotion processes at work with claims of deliberate favouring of least deserving white British colleagues. According to Likupe (2006), black African nurses reported experiences of discrimination and racism from their white colleagues, patients, and relatives as well as from their managers who treated them less favourably than their peers from white backgrounds.

Migrant nurses working in the National Health Service (NHS) have been found to be victims of workplace discrimination in conditions of service, task allocation and training opportunities. A qualitative study by Likupe and Archibong (2013) of black African nurses' experiences with the British National Health Service (NHS) found that the migrant nurses feel they are bullied and harassed by their white colleagues who, in some cases are caregivers working under them. This finding is consistent with earlier findings by Allan and Larsen (2003) that migrant nurses feel being bullied by care assistant colleagues of white British origin. Scholars suggest that such work environments breed interpersonal and intergroup tension capable of affecting employee job satisfaction and well-being (McLeod and Lobel, 1992).

In a study conducted to understand racial mistrust and interracial contact among Asian-Americans', Kohatsu, Dulay, Lam, Conception, Perez, Lopez, and Euler (2000) found that people including African Americans' and whites alike relate better with people of their own identity because of in-group preferences. A strong sense of social and group identification from dominant and less dominant groups encourages tensions leading to group anxiety, increased anger, low self-esteem, low work performance and motivation, high employee stress levels, depressive tendencies and generally low levels of employee well-being (Burchinal, Roberts, Zeisel and Rowley, 2008; Greene, Way and Pahl, 2006; Seaton, Caldwell, Sellers and Jackson, 2008; Neblett, White, Ford, Philip, Nguyen and Sellers, 2008; Wong, Eccles, and Sameroff, 2003). Smith, Allan, Henry, Larsen, and Mackintosh (2006) concluded that such perceptions contribute to the nurses' feelings of loneliness and limited their interactions at work, with

suggestions of unfair management of intergroup relationships at work. In a qualitative exploratory study of Chinese nurses working in Australia, Zhou, Windsor, Theobald and Coyer (2011) found that, along with feelings of discrimination, the nurses suffered isolation and constraint of positive interactions at work.

2.5.4 Measuring development

Training and development as both individual and organisational activities have beneficial outcomes (Salas and Cannon-Bowers, 2001). According to Warr (2002), learning as a cognitive outcome of training informs improvement in skills, knowledge, and attitude, which enhances employee job satisfaction and self-efficacy (Warr, 2002). Research suggests that when employees perceive training linked to their careers, their engagements are enhanced, translating to positive desirable work-related outcomes that are measured in both objective and subjective terms (Arthur, Khapova and Wilderom, 2005; Seibert, Kraimer and Crant, 2001). Training and career development continually emerge as a factor in both the transactional and relational components of an employee's psychological contract, given its utility in both short-term and long-term consideration of the employment relationship (Robinson, Kraatz, Rousseau, 1994). These are also measurable through objective outcomes in relation to upward career mobility, as observed in their promotions within the organisation or elsewhere with corresponding increases in incomes (Arthur, Khapova and Wilderom, 2005).

Henry (2007) noted the relationship between lack of management support and the limited career development of migrant nurses in the United Kingdom. The study argued that ethnic minority migrant nurses felt that they were not given same upward mobility opportunities as their white colleagues in terms of preparations for and notifications for promotional training opportunities. However, O'Brien and Ackroyd (2012) in their comparative case study and direct observation of cohort of overseas nurses working in NHS trusts in the North of England found that the inability of overseas nurses to appreciate differences in values, made it difficult for them to integrate within British value systems. This resulted to overt social hostilities and racist reactions of exclusion from full involvement in team-related activities and assignments.

In a study of Mexican migrants in the United States, Shinnar (2007) found that language barriers, individual goals, cultural values, and workplace discrimination impacted on the migrants' career development at work. However, in a study, Yakushko, Backhaus, Watson,

Ngaruiya, and Gonzalez (2008) found that migrants' inability to cope with stressful situations at work affected their career development. Kameny, DeRosier, Taylor, McMillen, Knowles and Pifer (2014) also argued that institutional informal practices and actions could impede the career success of minority groups such as migrants, who may be frustrated out of the system. This is principally where there are no support systems in place to manage situations such as loneliness, perceptions of dominant group actions and ignorance of processes at work.

In a hermeneutic phenomenological exploration of overseas minority and black nurses working in the UK National Health Service (NHS), Alexis and Vydelingum (2005) reported the nurses' perceptions of the lack of skill development opportunities for them within the system. The study suggested that in the development of persons and their careers, constant reviews and adjustments on training and knowledge are considered necessary. It further suggested that absence of effective identification of career needs of the nurses would have implications on their career development.

Contemporary career literature and research suggest greater employee initiatives and involvement in the management of their career development (Arthur and Rousseau, 1996; Lewis and Zibarras, 2013). Scholars believe that individual employees' personal initiatives and involvement in evolving and championing their training needs and expectations give them direct ownership of the process. (Briscoe and Hall, 2006; Eby, Butts and Lockwood, 2003). It is argued as well that this encourages personal initiatives in identifying knowledge gaps and aspirations, which bring about positive personal developmental outcomes (Megginson and Whitaker, 2007; Sturges, Guest, Conway, and Mackenzie-Davey, 2002). However, McDowall and Saunders (2010) argue that even as training and development may have differing connotations and purposes, organisational support interventions are necessary through managerial actions and roles. Managers who through engagement with employee aspirations guide them through careers notice outcomes for enhanced job satisfaction and performance (Chen, 2010).

According to Alexis and Vydelingum (2005), who examined the experiences of Filipino migrant nurses in the UK, they reported the same generic negative experiences, though the study had limitations in understanding what the nurses meant by "unmet expectations" as part of their negative experiences. Henry (2007) reported that migrant nurses attributed their constrained opportunities for skills development and training to their managers non

sympathetic approach to issues relating to their development. However, Amaro, Abriam and Yoder (2006), in a study which used a grounded approach to examine perceived barriers to educational advancement of ethnically diverse nurses in the USA, found socio-cultural concerns which tend to militate against the ethnically diverse nurses in undertaking or completing training programs.

In a study commissioned by the Royal College of Nursing, Pike and Ball (2007), using a survey data collection method to further explore experiences of black and minority ethnic internationally recruited nurses, found that about eighty percent of Afro-Caribbean nurses in the United Kingdom have additional jobs. The study concluded that amongst other reasons, migrant nurses' greater involvement in multiple employments, which were undertaken to cater for economic and financial responsibilities, provided limited time to engage with career development activities. It has also been suggested that black and minority nurses' lack of management support impact their motivation to take initiatives for their personal development as well as the absence of ethnic role models to prop them up (Aboderin, 2007; Allan and Larsen, 2003; Gerrish and Griffith, 2004; Smith, Allan, Henry, Larsen, and Mackintosh, 2006; Withers and Snowball, 2003).

Section summary: The above sub-section reviewed the previous research findings on perceived experiences of migrant nurses in the United Kingdom. The findings suggested the migrant nurses' reports of negative experiences at both structural and interpersonal relationship levels. The identified themes above reflect reasons for the migrant nurses' formation of feelings of negative experiences. The review highlighted, in part, aspects of expectations that may not be overtly "expressed" expectations of the nurses' employment contracts representing the "soft" set of expectations that need to be understood and managed (Sparrow, 1998).

While the above issues, as reviewed from previous research, highlighted the migrant nurses' feelings, the review also revealed vital gaps on theoretical underpinnings of the nurses' expectations, perceptions, and responses in their experiences at work, hence the current researcher's introduction of the exchange relationship theories and concepts to further explore the gaps as identified.

Chapter 3: Literature Review (2)

3.1 Understanding migrants' expectations and experiences: The contribution of theories of exchange relationships

The aim of the following review of exchange relationship theories, including the psychological contract construct, is to situate employees' expectations, consistent with the current research participants' possible entry-level expectations, organisation justice framework to explore perceptions of actions, events, and processes at work, the leader-member exchange theory (LMX) and leader member exchange differentiation (LMXD) to determine relationships and responses within expectations, experiences and implications on work relationships.

The present research aims to extend our understanding of the negative experiences reported in previous research on migrant nurses in the United Kingdom. In doing that, the present research examines West African migrant nurses' perceptions of their experiences, drawing on exchange relationship theories (Conway and Briner, 2009). These theories provide platforms for developing insight into the nurses' expectations, relationships, interactions, perceptions, and behaviours at work (Herriot, Manning, and Kidd, 1997). The exchange relationship theories in the present research followed suggestions Morrison and Robinson (1997), Rousseau (1995), Folger (1986) and Turnley and Feldman (1999) that experiences of fairness and the consequences of emotional and behavioural responses at work can be explained by employees' appraisal of the organisational structures and exchange relational dynamics. In the context of these, Milward (2005) argued that employees consider their interactions with managers, as organisational agents, or representatives, the medium through which to examine the mutuality of their exchange relationship. One of the influential constructs in organisational and employment exchange relationships which explains behavioural outcomes (Conway and Briner, 2005) is the psychological contract.

3.1.1 The psychological contract and types

The psychological contract (PC) in an organisation involves a subjective implicit exchange expectation of employees and their organisations. The PC has been variously studied more from the employee perspective as their overarching subjective expectations on management

over organisational practices (Luu,2016; Donohue and Nelson,2009) aside the formal contracts of employment. Basic to the psychological contract is the nature and processes of its formation and the mental model of expectations it presents as a result (Abu Dole and Hammou, 2015) with Linde (2015) suggestion that employee social cultural context could influence expectations. According to scholars (Simon and George, 2013), employee expectations of work occur in phases including pre-employment perceptions, early socialisation, later experiences, and evaluation of processes and interactions. This suggests that employees evolve expectations which form the basis for the dynamic revaluation of their exchange relationship over time. It is through these dynamic processes that employees engage in comparing expectations and actual experiences for any perceived gaps or breaches. Given the values of the psychological contract are subjective, scholars (Coyle-Shapiro and Kesler, 2000; Robinson and Rousseau, 1994; Wellie, 2007) argue that perceptions of breach are quite common. However, based on probabilities, met expectations would guarantee job satisfaction, reduce stress and burnout, and contribute to their overall well-being at work (Hazell, 2010). In a measure of the valued contents of the psychological contract, Herriot, Manning, and Kidd (1997) outlined employee expectations of employers' obligations to include, among others, provision of adequate training, meeting personal and family needs, consultation on matters affecting employees, allowing for discretion, humane management and recognition of contributions, provision of a safe working environment, equitable pay and benefits providing job security.

On the other hand, the employer expects the employee to demonstrate honesty and reliability, volunteering to do extra tasks that are outside the formal job description, demonstrate loyalty by following the organisation's policies and procedures, effectively perform roles and improve skills and knowledge to carry out assignments (Roehling, 1996; Rousseau and Tijoriwala, 1998). However, regardless of who is interpreting the exchange expectations, the perceived exchange relationship involves obligations and creates a strong lasting mental model of evaluation within employment and exchange relationships (Conway and Briner, 2005; Conway, Kiefer, Hartley, and Briner, 2014; Rousseau, 1995; Rousseau, 2004; Thomas, Au and Ravlin, 2003). The psychological contract literature suggests two forms of the contract, the transactional and relational, each of which is determined in relation to their focus, time frame, scope, and tangibility (Manning and Kidd, 1997; Millward and Hopkins, 1997; Rousseau, 1995; Rousseau and Parks, 1993).

3.1.1.1 Transactional contract

Transactional exchange expectations focus on expectations of material compensations and personal benefits. These are more of a tangible and short-term nature with expected rewards such as material payments, promotion, and bonuses, which can be observed (Rollinson, Broadfield and Edwards, 1998). There are expectations of maximising material gains from input expended within the organisation, which can be measured in terms of the individual's level of financial gains and the levels of the status and power acquired (Watts, 1992).

It is argued (Perrin, Hagopian and Huang, 2007) that the narratives of migrant employees' expectations of economic disparity between less-developed nations and developed nations greatly influence migrant nurses' strong expectations of transactional benefits such as better economic returns on wages and career progression. According to Gray and Johnson (2008), international migrant nurses have high economic needs because of the high expectations of supporting families in their home countries. According to Smith, Fisher and Mercer (2011) who applied transcendental phenomenology anchored on broad-based, open-ended interviews with overseas nurses working in western Australia, migrant nurses felt satisfied with their long working hours and the financial benefits that come as a result.

Development theorists (Humphries, Brugha and McGee, 2009) argue that migrant nurses from less developed countries and continents such as the Philippines, India and Africa place high values on economic earnings and remit more money than their counterparts from developed nations such as Australia, New Zealand and the US who also work in the United Kingdom. In a multi-site ethnographic study of Nepali migrant nurses in the United Kingdom, Adhikari and Melia (2015) found that migrant nurses' felt their expectations of career progression and professional development were not met because they were not offered training and career development opportunities. The nurses' linked training, career development to outcomes in promotions which could increase their income to meet their financial responsibilities back home in their country. While the study identified the felt breach in the exchange expectations, it did not suggest the reasons why the nurses missed out on their training and development opportunities nor why they continued to stay in their jobs even with perceptions of breach of their psychological contract.

3.1.1.2 Relational contract

The psychological contract literature on expectations identified relational expectations as socio-emotionally based, involving emotional exchanges that endure in a long-term relationship and a strong personal engagement. In this form of the psychological contract, employees' expectations and emphasis are on interpersonal relationships that could enhance personal and emotional wellbeing. For instance, employees may value a relational contract to help them to balance their work and personal family lives. For instance, employees that are inclined to such balances, relational expectations at work will form strong focus of their psychological contact. Kirrane & Buckley (2004) examined support at work and found that positive relational engagement of employees at work mitigated the stress of family-work conflict for employees. Frone, Russell and Cooper (1992) suggest that family-related pressures could increase stress levels in individuals, social support in organisations through group cohesion, interpersonal trust, and employee positive exchange relationship with managers, however, is argued to mitigate incidents of perceived psychological strain at work (Mclean, 1979; Beehr and McGrath, 1992).

According to House (1981), social support can be categorised into instrumental, emotional, informational, and appraisal support. These categories of support collectively define the nature and directions of how employees receive practical help, care, information and feedback that support their wellbeing and self-esteem. Social support at work could have consequences for employees' levels of emotional exhaustion and burnout (Eastburg, Williamson, Gorsuch and Ridley, 1994; Ray and Miller, 1991). It can also determine employee levels of absenteeism, job satisfaction, organisational commitment (Cordes and Dougherty, 1993; Firth and Britton, 1989) as well as turnover intentions (Raja and Johns, 2010).

In an exploratory qualitative study of occupational stress among Filipino migrant nurses working in Chicago USA, Connor (2011) found that Filipino migrant nurses felt excluded at work with the perceived loss of the sense of communal and family living that formed their values at home. The consequence of such a sense of loss of communal experiences within the work environment were reported to have affected both their well-being and performance. In understanding the further link between relational expectations at work and employee psychological wellbeing, O'Driscoll and Beehr (1994) argued that close supervision and rigid performance monitoring can lead to stressful feelings. However, while some employees can

effectively accommodate and tolerate uncertainties at the workplace with lower expectations of supervision and guidance (Cooper, Dewe, and O'Driscoll, 2001), others could require clarity, close guidance, and supervision in the form of social support (Cooper, 1998).

Many studies (Conway and Briner, 2009; Conway, Kiefer, Hartley, and Briner, 2014; Zhao, Wayne, Glibkowski and Bravo, 2007) report consequences following employees' perceptions of a breach of the psychological contract, including reducing contributions and service to organisations to restore equity in the context of spillover effects based on displaced aggression theory (Marcus-Newhall, Pedersen, Carlson, and Miller, 2000). In a study of Filipino employees, Bordia, Restubog, Bordia and Tang (2010) reported their negative attitudes to customers as a spill over behaviours following their perception of breach of their psychological contract. However, Conway, Kiefer, Hartley, and Briner (2014) and Johnson and O'Leary-Kelly (2003) found no relationship between perceptions of the psychological contract breach and helping behaviours to co-workers and service users. While employees' perception of breach of their psychological contract may not always result in spill over negative behaviours, impact on their organisational commitment has been reported. In a meta-analysis of the impact of psychological contract on work-related outcomes, Zhao, Wayne, Glibkowski and Bravo (2007), reported that impact on organisational commitment occur more in perception of breach of psychological contract even through in relative terms of the expectations of either transactional or relational. For instance, some employees who perceive breach of their transactional contract may wish to sue to recover tangible elements of their expectations instead of reducing their commitment. However, in their study on work outcomes of perception of psychological contract in Trinidad and Tobago, Addae, Parboteeah, and Davis (2006) reported a relationship between employees' perception of breach of psychological contract on grounds of lack of care and support and affective commitment and intention to leave organisation.

3.2 Organisational justice and migrants' experiences at work

The following reviews organisational justice as the framework through which employees engage expectations with experiences. The organisational justice literature presents a framework to understand employees' perceptions and experiences at work (Anderssen, 1996). According to Cohen & Greenberg (1982), with its foundation on the Aristotelian concept of "proportionate equality" with a mind-frame that all individuals are treated not only equally but also equitably, organisational justice relates to people's beliefs about the fair or just way things

should be done (Randeree,2008). In perceptions of organisational justice at work, employees evaluate and judge the allocation of resources and the fairness of the processes as well as on the nature of interpersonal relationships (Bies and Moag, 1986; Colquitt, 2001; Colquitt, Conlon, Wesson, Porter and Ng, 2001; Lewis and Zibarras, 2013).

In the adoption of organisational justice as a general construct which interfaces with equity theory, employees' engagement with and perceptions of fairness of procedures and interactions at work could trigger emotional and behavioural responses (Kickul,2001).These responses could be noticed in job performance, organisational commitment, and citizenship behaviours. In their study, Cohen-Charash and Spector, (2001) related high turnover to negative perceptions of distributive justice, which is one of the three types of organisational justice. Organisation justice theory has been used to understand contemporary organisational phenomena such as discrimination, control, and motivation as well as evaluation of organisational effectiveness (Lewis and Zibarras, 2013; Podsakoff, Podsakoff, Mackenzie, Maynes, Trevor, and Spoelma, 2014).

Li and Cropanzano (2009) argued that organisational justice could be socially constructed with regards to how equity and equality are felt and measured across cultures. In a study of organisational justice and work outcomes in a non-Western country, Arab and Atan (2018) reported mixed results with indications that there are few differences in the expectations and perceptions of the process of the organisational justice in Western and non-Western countries. While the study found relatively small effects on distributive justice and job performance, it found a huge effect on outcomes in employees from a background of collectivist cultural values. For instance, the study found that such employees' perceptions of interactional justice influenced trust in their managers. The findings reported above suggest that the procedural, distributive, and interactional justice may be particularly important in the exchange relationship between migrant workers and their employers. The implications of this review for the current research suggests that West African migrant nurses might respond different in given situations of their experiences at work.

3.2.1 Procedural organisational justice

Procedural organisational justice is determined by evaluating the fairness with which methods, mechanism and processes are implemented within the organisational setting (Folger and Cropanzano, 1998). Procedural justice deals with and evaluates both proactive and reactive processes at work regarding not only issues such as dispute resolution but also fairness of decisions taken on any course of action. People are likely to think an outcome is fair if they think the processes or procedures leading to outcomes were fair. Perceived justice in procedures has been found to impact work behaviours such as intentions to leave, organisational commitment and citizenship behaviour (Cropanzano and Greenberg, 1997).

Organisational citizenship behaviour (OCB) exhibited by an employee's exertion of discretionary efforts has its antecedent from employees' perception of fair work processes (Lambert and Hogan, 2013). Perception of fair processes may be noticed in employees reduced intentions to leave the organisation as well as in their positive interpretations of actions of their managers and/or leaders. These outcomes are trust-based following employees' perceptions of their managers and organisations adoption of fair processes at work (Dolan, Tzafrir, and Baruch, 2005; Saunders and Thornhill, 2003). In a study, with data collected from 482 nurses working in the European district of Istanbul, Altuntas and Bayka (2010) reported findings of high levels of organisational citizenship behaviours amongst the nurses following trust in their managers, co-workers, and organisations.

Employees' perception of fair processes is reported as positive predictor of job satisfaction which has impacts on organisational citizenship behaviour. In their study, Usmani and Jamal (2013) found that employees, especial from collectivist societies reported high job satisfaction because of their perception of fair processes in their organisations. Organ (1988) suggests that, in demonstration of organisational citizenship behaviours, employees display senses of altruism, consciousness, courtesy and civic virtues which promote organisational and pro-social values. In a study of employees' level of job satisfaction and their demonstration of organisational citizenship behaviour, Murphy, Athanasou, and King (2002) found a positive relationship between service givers' job satisfaction and their demonstration of organisational citizenship behaviours. The study reported employees voluntarily participated in fund raising,

increased membership of committees, promoted work-related activities and increased attendance at other work-related social functions. The workers' demonstration of discretionary work ethics without additional pay confirms their trust in their organisation and the demonstration of a sense of organisation-based self-esteem. In their study, Pillai, Williams, and Tan (2001) reported a positive relationship between employees' perceptions of fair processes and trust in their organisations. In a sense, employees' perceptions of organisational processes guarantee positive outcomes for them enhance their engagement in extra role or contextual behaviours at work (Mayfield and Taber, 2010; Motowildo, 2000; Finkelstein and Penner, 2004).

In their study, Geddes, Merriman, Ross, and Dunlap-Hinkler (2003) reported that with employees' perceptions of fairness in decision making processes, there is also greater sense of organisational membership. On the other hand, perceptions of unfairness would potentially trigger employees' counterproductive work behaviours (CWB) with outcomes observable in workplace defiance and dysfunctional behaviours (Bennett and Robinson, 2000; Rotundo and Sackett, 2002). Anti-organisational behaviours are not only discretionary but deliberate and can be targeted at the organisation or other organisational members (Robinson and Bennett, 1995).

3.2.2 Distributive organisational justice

Distributive justice is determined by how organisational resources and rewards are fairly allocated. It is an evaluation of the outcome of process leading to the distribution of resources or rewards. In an individual's comparisons of contributions to organisational output and outcomes and feelings of deprivations in rewards and resources from such contributions, the grounds of equity are established. Similarly, a group sense of deprivation based on intergroup comparisons on the grounds of characteristics such as race and/or age would lead to both subtle and obvious challenges on the fairness and legitimacy of the process (Martin, 1993). However, distributive justice may not be just about equity. Other important grounds for distribution could be equality and need. Equality and need could be the basis for the distribution of resources like training and aspects of workload like shift patterns at work.

In the context of the distributive justice process, employees' perceptions of imbalance between inputs and outcomes in reward in comparison to referent others would trigger behaviours that could balance the feelings of unfairness (Cropanzano and Greenberg, 1997). In the context of

organisational resources and rewards that are measured in possible tangible items such as salary, promotion, bonus, recognition and job status, employees weigh these outcomes against their inputs, which could be in terms of experience, training, skills, education, and ideas that go into the realisation of organisational goals and effectiveness. Employees' perceptions of possible flaws in the management of these processes is a predictor of demonstration of organisational citizenship behaviour and other organisational attitudinal variables (Organ and Ryan, 1995; Williams, Pitre, and Zainuba, 2002).

3.2.3 Interactional organisational justice

In its practice, interactional justice informs how sensitivity relates to individual employees such as being open and frank about sharing information and explaining within informal settings why and how decisions or actions are taken. In its relationship with procedural justice, the judgement of interactional justice is used by employees to determine whether a leader's informal relationship with the referent other is based on fairness, equity, and equality. Thompson and Heron (2005) and (George and Zhou (2007) suggest that high levels of interactional justice align with the relational form of the psychological contract, fosters organizational commitment while promoting a supportive work environment.

The psychological contract as reviewed above and its appreciation through the framework of the organisational justice highlighted employees' expectations which could be implicitly coded but through which they evaluate the support they receive at work to enhance their organisation-based self-esteem. Organisation-based self-esteem represents employees emotional state of mind on perceptions of support from their organisations to make them feel part of it. These expectations of support would form part of their experiences, which could be applicable to the participants of current research.

3.3 Perceived organisational support (POS)

In this sub-section, the researcher reviews what support means to employees.

Perceived organisational support represents employees' feelings that an organisation cares about their well-being and values their contributions to the organisation (Eisenberger, Huntington, Hutchison, and Sowa, 1986). Employees operate in organisations to meet not only organisational goals but also their personal goals (Folger, 1993). Research (Kraimer, Wayne,

and Jaworski, 2001; Shore and Wayne, 1983) suggests that perceived organisational support has a positive impact on such organisational outcomes as organisational commitment, pro-social behaviours and employees' senses of job satisfaction and performance. Arguments are that supervisors and/or managers play dual roles in the organisation in their personal capacities as employees roles models and as agents of their organisations (Cheng, Jiang, and Riley, 2003). Scholars (Eisenberger, Stinglhamber, Vandenberghe, Sucharski, and Rhoades, 2002; Maertz, Griffeth, Campbell and Allen, 2007) believe that the employees' evaluation of their managers actions has consequences on the employees, hence perceived organisational support (POS) and perceived supervisor support (PSS) are considered synonymous considered that actions of goodwill from the manager to the employee may represent support from the organisation.

Cross-cultural research suggests that, while positive and well-directed organisational support moderates positive organisational and employee well-being for international employees (Caligiuri, Hyland, Joshi, and Bross, 1998), there are challenges in appreciating what constitutes support for these employees with differences in needs and motivation because of value differences. For instance, while some employees' individualistic values are driven by self-identities in social relations, others with collectivist values are driven by in-group relations, social harmony, and loyalty -protection relationships at work (Church and Katigbak, 1992; Yamaguchi, 1998).

In general circumstances though, international employees experience possible common issues following their international relocation, including family disruptions (Kraimer, Wayne and Jaworski, 2001) and breakdowns in career and community ties, boredom, isolation, and the evident cultural shock (Black and Stephens, 1989). However, the concerns in appreciating the nature and extent of organisational support are argued to be related to unfamiliar management styles and differences in cultural values such as differences in social realities on family relationships and ethics and non-appreciation of these contexts (Gregerson and Black, 1992; Lober, 1992). Further to the value differences mentioned, research (Gripenberg, Niemistö and Alapeteri, 2013) suggests that gender value differences impact needs and perceived organisational support in relation to socially constructed identities and expectations (Alsop, Fitzsimmons, and Lennon, 2002; Hobson and Fahlén, 2009).

In a study that looked at the support needs of women on international assignments, Puchmüller and Fischlmayr (2017), found that family-related forms of social support were important for

women. The study noted the cultural dispositions of the women with suggestions that the cultural backgrounds of the women affected their traditional roles and the form of support expected. While women from individualistic societies would rely more on the instrumental support of friends as a form of social support, women from collectivist value backgrounds relied more on extended family members, probably because of the sense of communal and social cohesion in such societies. However, the common denominator from the study suggests that social support driven by family values and expectations resonated more strongly in the support expectations of the women. The participants in the study mentioned more issues about childcare and talked more about family acceptances, especially of spouses, which suggests that despite their focus on their careers, females are still conscious of their socially constructed identities in families.

In some societies, the expectations of women extend beyond their roles as career roles to a combination of their professional roles and family-related roles, hence they bear more psychological strains on the transition to a different country. This is more from the demands of emotional support because of many of the women feeling a sense of guilt living in new destinations without families (Fischlmayr and Kollinger-Santer, 2014). The demand for organisational support, therefore, becomes not only necessary but also in a form that is appropriate because it is argued that, while males may be appropriately engaged with friends and colleagues, females feel the sense of support more from social support from families, including spouses when applicable (Hutchings., French, and Hatcher, 2008).

3.4 Cultural influences on perceptions of work processes

The following review therefore examines literature on cultural values and implications on contemporary work environment. In the context of expectations, the reviews examine that nature of migrants' value expectations at work in destination countries.

In considerations of fairness and values, Weber and Gillespie (1998) observed that individual values and norms that are consistent with culture contribute to the evaluation of events and situations as well as impacting attitudinal and behavioural responses. Cultural dimensions vary across societies and may influence perceptions of work experiences (Bond, Leung, and Wan,

1982; Hofstede, 1980; Leung and Bond, 1984; Tyler, Lind and Huo, 2000). These differences were also found in considerations of equity and equality. While the individualist societal values emphasise interest in processes that determine autonomy and achievements, the collectivist values engage and focus more on processes that promote interpersonal relationships.

In a cross-sectional study of 151 overseas qualified nurses working in South Australia, Bhandari, Xiao and Belan (2015) found the nurses' perception of deliberate isolation and discrimination by the native employees and an equal sense of denial of career advancement opportunities affected their job satisfaction. Migrant nurses' perceptions of their managers not being fair in work distribution and allocation further increased their perception of conscious prejudices at work, including perceived deliberate denials of upward professional career mobility (Kishi, Inoue, Crookes and Shorten, 2014; Obrey and Vydelingum, 2005; Walsh and O'Shea, 2010).

In a case study of migrant nurses from India, the Philippines and Spain working in the United Kingdom, O'Brien and Ackroyd (2012) found that, while there are background cases of discriminatory practices through the skewed allocation of tasks, some migrant nurses avoided adapting to the United Kingdom cultural values and would rather keep their native beliefs and practices. This increased tension within the British staff, who excluded the migrant nurses from team-based cooperative work, hence increase in suspicions of motives and tension on interpersonal and group relationships.

According to Erez and Earley (1993), perceptions of breach of the exchange expectations could elicit responsive behaviours that are culturally normative. Both the emotional and behavioural responses that are exhibited following a perceived breach could be a result of the individual employee's cognitive interpretation of the circumstance or background of the breach (Morrison and Robinson, 1997; Rousseau, 1995). Similarly, Lind, Tyler and Huo (1997) argue that cognitive consequences of perception of organisational justice contexts and processes are in the domains of attitudes and behaviours which could be culturally conditioned (Thomas and Au, 2002; Thomas, Au, and Ravlin, 2003; Weick, 1995).

However, given the limited amount of research on how cultural values influence perceptions of exchange relationships, a generalization of possible employees' responses could be misleading (Farh, Zhong and Organ, 2004; Masterson, Lewis, Goldman, and Taylor, 2000;

Podsakoff, Mackenzie, Paine, and Bachrach, 2000). In a study of a sample of Americans and Hong Kong Chinese, relating to their psychological contracts, consequences, and responses to breach, Kickul, Lester and Belgio (2004), found differences between the two cultural groups on how they perceived and responded in their exchange relationships. While it could have been assumed that only the Americans would be more sensitive on breach of their transactional forms of the psychological contract such as in promotion and pay, the Chinese reported breach because of their perception that their lack of training denied affected their ability for both upward mobility and pay rise. However, in a study, Street (2009), found that Japanese employees who share collectivist cultural values embraced more of the relational aspects of the psychological contract. This suggests that based on their cultural considerations, they would prefer a closer informal relationship with their managers and colleagues. The implication of these findings suggest probable overlaps in expectations and values of the transactional and relational psychological contract, depending on the circumstances (Kickul, Lester and Belgio, 2004).

In their study, Thomas, Fitzsimmons, Ravlin, Au, Ekelund and Barzanty (2010) collected data through semi-structured interviews with multinational employees from Canada, France, Norway, and China. While traditionally, based on cultural backgrounds and conceptions, a specific outcome was expected, perceptions of the psychological contract based on earlier held cultural value schemas changed. The findings rather suggested that some of the participants adjusted to their current work environment through effective organisational socialisation. The interpretation of this finding suggest the ability of for employees to embed sufficiently enough in their new work environment through a determined approach of adaptation. In the circumstances, employees applied sense making using organisational sources rather than from different referent values (Thomas, Au, and Ravlin, 2003; Weick, 1995). In such cases, employees' perceptions of breach of their psychological contract would be minimal because of their feelings of organisational membership and greater involvement with organisational processes (Morrison and Robinson, 1997; Teklead and Taylor, 2003; Thomas, Au and Ravlin, 2003).

However, the scope of an employees' organisational socialisation is argued to depend sometimes on extent on communication and language abilities (Bovillian, 2013). Difficulties in self-expression could lead to incidents of unconscious exclusion and self-isolation. In a

qualitative study of mainland Chinese international migrant nurses working in the United States, Xu, Gutierrez, and Kim (2008) found that, as a result of language difficulties, nurses felt they were over-micromanaged for mistakes at work. Obrey (2015) found that internationally recruited nurses in the United Kingdom felt isolated at work because of communication issues.

While, both Xu, Gutierrez, and Kim (2008) and Obrey (2015) found that language difficulties could cause people to be isolated or misunderstood, the nature and process of migrant induction and adaptation processes could impact on their engagement at work. This is pertinent given that organisational socialisation in some cases could involve the use of deep-rooted socio-cultural colloquial accents and slangs, especially by the natives. In Cumming's (2009) study of migrant nurses, it was found that the limited time frame of migrants' adaptation did not prepare them well enough to face the challenges that cultural differences posed at work. Similarly, in a qualitative study of Chinese nurses working in Australia, Zhou, Windsor, Theobald and Coyer (2011) found that, even though the nurses can express themselves in a standard work language, they felt isolated and commonly emotionally weakened because they could not understand the commonly used native slangs, idioms and humour which impacted on their ability to join in social activities. In contrast, migrant nurses who attain higher levels of language competency exhibit a sense of belonging and inclusion and are more likely to report positive migration experiences (Magnusdottir, 2005).

3.5 Cultural influences on perceptions of breach in exchange relationships

When organisations and/or their agents fail to honour their exchange relations obligations employee perceptions of breach occur. Morrison and Robinson (1997) identified categories through which an exchange breach could occur. In their seminal work, they argued that breach can occur as a result of the lack of awareness of either party's expectations. Diverse employee demographics, as in the cases of migrants with different needs, concerns, and interests, may impact the understanding of issues relating to the exchange expectations (Morgan and Finniear, 2009). A possible lack of understanding of culturally based expectations would make organisations and or their agents liable to be prescriptive in addressing issues involving such employees with varying needs (Guzzo and Noonan, 1994).

Many organisations are suggested (Morgan and Finnear, 2009) to lack clear articulation of the needs, concerns, and general expectations of their employees in diverse work environments. The psychological contract has been employed to understand specific national work and organisational issues such as Krishnan (2011) using India samples, Davila, and Elvira (2007) using Mexican samples, Pate, Martin, and McGoldrick (2003) using British samples and Chambel (2014) using Portuguese samples. However, its use in research to understand expectations in multicultural work environments is still sketchy.

The psychological contract's perception and interpretation depend to an extent on how each party to the contract evaluates it (McLean Parks and Schmedemann, 1994; Rousseau and Schalk, 2000). However, and regardless of who is interpreting the exchange expectations, the perceived exchange relationship involves obligations and creates a strong lasting mental model of evaluation within employment and exchange relationships (Conway and Briner, 2005; Conway, Kiefer, Hartley, and Briner, 2014; Rousseau, 1995; Thomas, Au and Ravlin, 2003). In this research, the psychological contract is used interchangeably with implicit exchange and expectations.

The psychological contract breach is the failure to meet obligations which voids expectations (Conway and Briner, 2009; Rousseau, 1995). This results in consequences with strong influences on work-related outcomes, including job satisfaction (Cammann, Fichman, Jenkins, and Klesh, 1983; Robinson and Rosseau, 1994), organisational citizenship behaviour (Turnley, Bolino, Lester and Bloodgood, 2003), organisational commitment (Lester, Turnley, Bloodgood and Bolino, 2002; Meyer, Allen, and Smith, 1993; Turley and Feldman, 1999) and intentions to leave the organisation (Becker, 1992; Kickul and Lester, 2001). While previous research on the experiences of migrant nurses in the United Kingdom did not examine perceptions of the nurses' negative experiences with regards to either behavioural or organisational outcomes, the present research explores into deeper issues of West African migrant nurses' expectations and their perceptions of experiences in relation to those expectations.

3.6 Cultural influences on coping adjustments to exchange breach perceptions

Morrison and Robinson(1997) argue that perceptions of a psychological contract breach have consequences because of the natural behavioural reaction to balancing feelings in the exchange. This is to further adjust through both behavioural and cognitive responses to cope with the perception of a breach and its attendant psychological strains. Stress as a response to stimuli from the physical, social, or psychological environment, when associated with perception of psychological contract breach is reported to have an impact on employee personal well-being. Cooper, Dewe, and O'Driscoll (2001) suggest that employees' perceptions of deliberate exclusion from organisational decision-making processes, lack of trust and lack of organisational support could lead to build up on psychological strain. Grimmer and Oddy (2007) argue that within such circumstances and perceptions, employees could resort to engage in coping mechanisms to restore the status quo in terms of well-being and motivation.

Coping according to Carver, Scheier and Weintraub (1989), is an intentional cognitive or behavioural attempt to relieve or manage stress-induced psychological strains following negative feelings. While there are still gaps in determining the mechanisms of coping with work and occupational stressors, research (Chun, Moos, and Conkrite, 2006) suggests that individuals could adopt mechanisms that are culturally value-laden in coping with stress and its causes in the workplace.

In studies, both O'Connor and Shimizu (2002) and Oláh (1985) found that participants from collectivist societies of Asia adopted emotion-focused, escape-avoidance and positive reappraisal as their main forms of managing stressors, while their European and UK counterparts adopted problem-focused operative mechanisms. Similarly, Chian, Hunter and Yeh (2004), who studied the coping strategies of Africans, Americans, and Latinos, found that Africans adopted more spiritual and family resources in their mechanisms because of their traditional and cultural affiliations to spiritual and family values. However, these methods of coping may not be the only way in which employees respond to a breach in their psychological contract (Krause and Moore,2018).Employees' perception of breach or violation of the psychological contract could result in their re-engagement in a different form of the contract as a coping mechanism while keeping their jobs. This renegotiation of contracts could be determined by the values associated with the new aspects of the contract and the employees' new sense of motivation. The psychological contract construct provides understanding that

employees including migrants, have expectations on work and personal wellbeing at destination countries, including the United Kingdom and would anticipate the fulfilment of such expectations.

Previous research reported migrant nurses' perceptions of negative experiences in the United Kingdom, the present research aims to further insights on the nurses' perceptions and experiences. The immediate previous sub-section of the literature review examined the nature of expectations within circumstances of cultural values. In circumstances of employees' perceptions of non-fulfilment of expectations under any circumstances, the following sub-chapter reviews literature on employees' responses, behavioural and emotional within such perceptions.

3.7 Organisational commitment: A gauge for employee perception of work

Organisational commitment as the yardstick for gauging employee dedication to the organisational course mirrors in relative terms the identification and involvement of an employee with the organisation (Milward, 2005; Mowday, Porter and Steers, 1982). Organisational commitment is characterised by an employee's general attitude that reflects the acceptance of the organisation's goals and values with self-determined acts of putting in extra efforts and desiring to remain with the organisation (Rollinson, Broadfield and Edwards, 1998). Organisational commitment is inversely related to turnover, with employees maintaining regular attendance and participation at work. Organisational commitment is also a negative predictor of absenteeism (Harrison *et al.*, 2006). Meyer and Allen (1991) identified three dimensions of organisational commitment including affective, continuance and normative commitment. These are based on three characteristic elements: the acceptance of organisational goals and values, the willingness to exert efforts on behalf of the organisation and the intentions to remain with the organisation (Dipboye, Smith. and Howell, 1994; McCaul, Hinsz and McCaul, 1995).

3.7.1 Affective organisational commitment

Affective organisational commitment guarantees an emotional attachment of the employee to the organisation (Meyer, Allen, and Smith, 1993). According to the literature, the affective component of organisational commitment represents the most current and variously used in understanding employee dedication at work.

In their study which measured perceived organisational support, Maertz *et al*, (2007) suggested that employee attachment to the supervisor would sustain affective commitment. Affective organisational commitment presents as the most influential of the commitment components because of its association with intrinsic motivation rather than extrinsic motivation. Organisational work processes such as perceived organisational support, organisational justice, and effective and relational leadership, which are evaluated as positive by employees, are reciprocated through the demonstration of psychological attachment to the organisation and its values and goals (Meyer, Stanley, Herscovitch, and Topolnytsky, 2002).

In organisational behaviour, perceived organisational support is recognised as one of the variables impacting affective organisational commitment (Perry-Smith and Blum, 2000), with expectations of obtaining organisational resources such as information needed to carry out tasks, provision of socio-emotional support, caring and respect. In the spirit of social exchange theory, the commitment of employees will be positively related to the perception that the organisation values their contribution and, equally, has an interest in their well-being (Eisenberger, Huntington, Hutchison, and Sowa, 1986). This enhances the sense of affective commitment (Grant, Dutton, and Rosso, 2008). Conversely, employees' perceptions that their interests and well-being are not managed properly as result of perceived unfair organisational processes, would result in negative work outcomes such as turnover intentions (Rhoades, Eisenberger, and Armeli, 2001)

3.7.2 Continuance organisational commitment

The continuance dimension of organisational commitment reflects the level and nature of commitment through which employees evaluate the cost of leaving an organisation in relation to various personal investments, including relational, which have been made over time (Dipboye, Smith. and Howell, 1994; Matthieu and Zajac, 1990). One of the fundamental

determinants in the demonstration of continuance commitment is argued to be age, based on an employee's consideration of the length of service put into the organisation as well as relationships formed during the period.

However, other variables, such as availability of alternative jobs, complexities of searching for other jobs and relationships developed within the workplace can also predict levels of continuance commitment. The difference between affective and continuance commitment in relation to intentions to leave is determined from the assumption that employees with high affective commitment want to stay while employees with high continuance commitment feel they must stay (Meyer, Allen and Gellatly, 1990).

3.7.3 Normative organisational commitment

This component explains employees' intentions to remain with the organisation based on positive experiences and interactions with other organisational players. According to Meyer and Allen (1997), normative organisational commitment comes with internalized feelings that have occurred to individual employees' overtime in the organisation leading them to feel that they should stay with the organisation. According to Bartholomew and Perlman (2005), affective bonding happens every day in organisations through interactions among organisational members. In the same understanding, employees consider their interactions with agents of the organisation such as the managers as direct involvement and engagement with the organisation (Rousseau, 1995). Some employees may not have a strong or emotional attachment to the organisation but given other circumstances, they may wish to stay on. It has also been argued that characteristics such as age, ethnic origin, gender, and tenure could explain differences in normative organisational commitment.

The quality of the relationship and socio-emotional support experienced by employees has been found to be positively moderated by high-quality leader-member exchange, which reduces turnover intentions and increases employee contributions to the organisation (Armeli, Eisenberg, Fasolo and Lynch, 1998; Rhoades and Eisenberg, 2002). Normative organisational commitment has also been advocated to develop among organisational members with structures that support their psycho-social and career interest mentoring (Bozionelos and Wang, 2006). It is plausible to argue that employees from a collectivist cultural background would benefit from environments which would enhance their sense of socio-emotional and

career support because of their value inclination to social and paternalistic relationships. Research (Chan, Feng, Redman, and Snape, 2006) suggest that employee perceptions of co-worker socio-emotional support in addition to perceived supervisor support mediate perceived organisational support translating in low turnover intentions.

However, irrespective of the nature and type of commitment, scholars (Fleck & Inceoglu, 2010; Macey, Schneider, Barbera and Young, 2009) are of the view that employees' perceptions of a supportive work environment, effective communication and fairness drive organisational commitment and impact both perceptions of psychological contract breach and intentions to leave. The outcome of this is the argument that, with perceptions of fair organisational processes, employees are less inclined to negatively evaluate possible traces of breach in exchange relationships because of the level of trust existing amongst organisational members.

In a study of a racially distributed sample of 234 professionals, Suazo, Turnley and Mai-Dalton (2005) found that, with perceptions of a breach of their psychological contracts, employees would not only attempt to leave their organisation but would also leave their professions and careers. In such situations, employees would lower their productivity and participate less in team working in the organisation. While this is a natural behavioural reaction to balancing feelings in the exchange relationship, Trybou, Maaïke, Elke and Gemmel (2016) found that nurses who perceived unfavourable treatment which they interpreted as breach of their psychological contract displayed responsive attitudes and behaviours of anger and betrayal. Similarly, Rodwell and Ellershaw (2016) in their study, involving 459 Australian nurses reported the nurses' perceptions of negative experiences of lack of trust and communication interpreted to be consistent with perceptions of breach of their psychological contract leading to work-related outcomes of intent to leave and organisational commitment.

These reported perceptions and responses are consistent with arguments that employees' perception of work overload and lack of organisational support not only impact on their mood and general well-being but also produce affective responses in form of organisational cynicism and other sabotaging activities (Conway and Briner, 2002; Morrison and Robinson, 1997; Pugh, Skarlicki and Passell, 2003). In a study on work intensification and coping, Ogbonna and Harris (2004) found that academic professionals are exposed to intense strains which led to their display of 'fake' emotions as they attempt to meet expectations within

work environments of increased responsibilities and decreased resources. The implication of this finding on perception of work environment and wellbeing on the present research may be that the nurses may adopt different coping strategies in their perception of experiences at work.

The psychological contract construct as reviewed above introduced expectations at work. Further reviews showed the dynamics of cultural values in expectations at work with subsequent literature on employees' possible responses to circumstances of perceptions of non-fulfilment of expectations. The following subsection of literature examines employees', including migrants' evaluations of experiences in relation to their expectations at work.

3.8 Migrants' evaluations of experiences and engagement at work

Employment relations theorists (Liden, Bauer, and Erdogan, 2004), suggest the centrality of an employee's immediate manager in the organisational exchange relationship. While managers serve roles and carry out responsibilities in the best interest of their organisations (Lester, Turnley, Bloodwood and Bolino, 2002), they are continuously placed under scrutiny by other stakeholders, including their employees. It is through such scrutiny that employees perceive and determine the nature and of their engagement at work (Coyle-Shapiro and Shore, 2007; Tekleab and Taylor, 2003).

In separate studies, Aryee, Budhwar and Chen (2002) and Malasta and Bryne (1997) suggested that in understanding exchange relationships at work, supervisors' and managers are sources and anchors through which employees evaluate their experiences in relation to their expectations. Managers are considered metaphoric windows through which employees make sense of the organisational ethos (Eisenberger, Huntington, Hutchinson, and Sowa, 1986; Levinson, 1965). Consequently, it is likely that managers will be a focal point for migrant nurses when they evaluate their experiences in relation to their expectations. In a descriptive qualitative study, which investigated how migrant Hispanic nurses defined their work environment, Moceris (2013) found that, when the nurses perceived lack of support and unfair treatment from their managers in relation to the nurses' perceptions of non-recognition and or undervaluation of their contributions, they viewed their organisational environment as biased and difficult.

In a Canadian study, Higginbottom (2011) found that migrant nurses' perception of negative experiences at work were linked to their perceptions of discrimination by their managers in terms of being excluded from challenging tasks and responsibilities. Managers and/or supervisors assume responsibilities for managing policies and processes as well as exerting authority and power over employees in the best interests of their organisations (Agelage and Eisenberger, 2003; Katz and Kahn, 1966; Levinson, 1965). It is argued that the positions of supervisors or managers place them as principals of their organisations in any exchange relationship with employees (Aggarwal and Bhargava, 2009; Herriot and Pemberton, 1997; Rousseau, 1995; Teklead and Taylor, 2003).

In their routines and through monitoring work processes, managers evaluate, respond, and give feedback to employees on their behaviours and performance (Coyle-Shapiro and Parzefall, 2008), hence interpersonal relationships between managers and employees are crucial because they predict other organisational outcomes (Dansereau, Graen and Haga, 1975; Graen and Cashman, 1975). Manager-employee relationships influence organisational outcomes as job performance, job satisfaction, psychological well-being, and organisational commitment (Bowling and Beehr, 2006; Duffy, Ganster and Pagon, 2002). A positive relationship between the managers and employees is vital in managing employees' negative perceptions of the organisation's processes and perceptions of breach of the psychological contract (Turnley and Feldman, 1999). The above suggests the essence of leadership in determining both human and material outcomes in organisations.

3.8.1 Organisational leadership influences

The idea of relationships in an organisation is anchored on the realisation of the dynamics of power and authority of leadership. Power in its ordinary term is the ability to influence the behaviour or values of another (Rahim, 1989). This denotes an instrument of influence from a base or point of such influence. From the organisation's point of view, leadership and power are perceived jointly with the sense that the leader sits in a position of power to reward and to punish depending on the circumstances. The exercise of power and authority in organisations leads to organisational outcomes because of its influential and emotive nature (Afzalur Rahim, Abbas, and Uddin, 1994; Farmer and Aguinis, 2005). Within the framework of "locus of control", power is seen as a source of rewards and coerciveness associated with leadership (Elangovan and Xie, 1999) which influences organisational socialisation and interactions and

access to organisational information and resources with employees aligning themselves to secure the maximum benefits of organisational resources. Perceptions of their positions in this alignment, therefore, are of maximum importance to employees (Mossholder, Bennet, Kemery and Wesolowski, 1998).

The leader-member exchange represents efforts in the direction toward benefiting from a relationship with organisational leadership. Organisational leadership drives efforts to transform resources for organisational effectiveness through coordination and use of power and authority to manage resources of the organisation (Elias, 2008). In the use of organisational power and authority, Werth, Markel and Förster, (2006) argue that employees perceive leadership and use of power from different perspectives depending on their mental structures and cognitive schemas. The use of power and appeal of the leadership might be related to an employee's own sense of judgement. With the above review on employees' determination of their anchor of relationships at work, the following literature is examined on how exchange relationships between managers and their subordinates, in this case, the migrant nurses could work. The dynamics of the leader member exchange theory and the leader member exchange differentiation are therefore reviewed.

3.9 The Leader-member exchange (LMX)

The Leader-member exchange theory is relevant in this research because it identifies a process by which employees' attitudes and behaviours are shaped within the employment and exchange relationship (Erdogan and Liden 2002; Rousseau, 1998; Shore, Tetrick, Coyle-Shapiro and Taylor, 2004; Teklead and Taylor, 2003). The leader-member exchange (LMX) theory suggests a trust-based relationship between leaders (managers) and their subordinates (Graen and Uhl-Bien, 1995), which when managed properly produces positive organisational outcomes. Scholars suggest a relationship between the psychological contract perception of a breach and the quality of leader-member exchange relationship in moderating trust perceptions and intentions to leave the organisation (Dulac, Coyle-Shapiro, Henderson, and Wayne, 2008). With effective communication between employees and their managers driving processes improvements, Graen and Cashman (1975) argue that employees connect easily with organisational vision. The leader-member exchange relationship has been linked to employee's career successes with the manager acting as a lift in advancing employee

opportunities, depending on the quality of the relationship they share (Wayne, Liden, Kraimer, and Graf, 1999; Erdogan and Bauer, 2015).

On examining the implications of leader-member interactions, Bull Schaefer (2010) argues that employees' quality of relationship with their managers determines how the employees value their organisations. The quality and direction of this relationship are predicted to impact work behaviours because employees monitor and evaluate the organisation through the actions and relationships with managers, seen as the agents (Deluga, 1994; Wayne, Shore, and Liden, 1997). Employees' perceptions and confirmation of positive relationships with and actions of the managers correlates positively to extra role behaviours (Dansereau, Graen, and Haga, 1975) and equally moderates employees' sense of organisational commitment and job satisfaction (Green, Anderson, and Shivers, 1996). In a study that applied the leader-member exchange theory to understand the impact of the supervisor-subordinate relationship and trainee characteristics upon police officers' work outcomes, it was found that high-quality exchange relationships accounted for less friction and increased employees' affective organisational commitment (Brunetto, Teo, Shacklock, Farr-Wharton, and Shriberg, 2017).

3.9.1 The LMX: Developing and sustaining the exchange relationship

In the present research, migrant nurses' expectations and experiences are examined in the context of their interactions and development of relationships with their managers. Erdogan and Bauer (2015) propose in figure (3.1) below the existence of a functional dyad relationship between managers and subordinates that determines organisational outcomes. The figure lists the antecedents that encourage a relationship between employees and managers and outcomes in terms of beneficial consequences for the employees and employers.

Fig (3.1) Summary of Antecedents and Consequences of LMX Relationships (Erdogan and Bauer 2015)

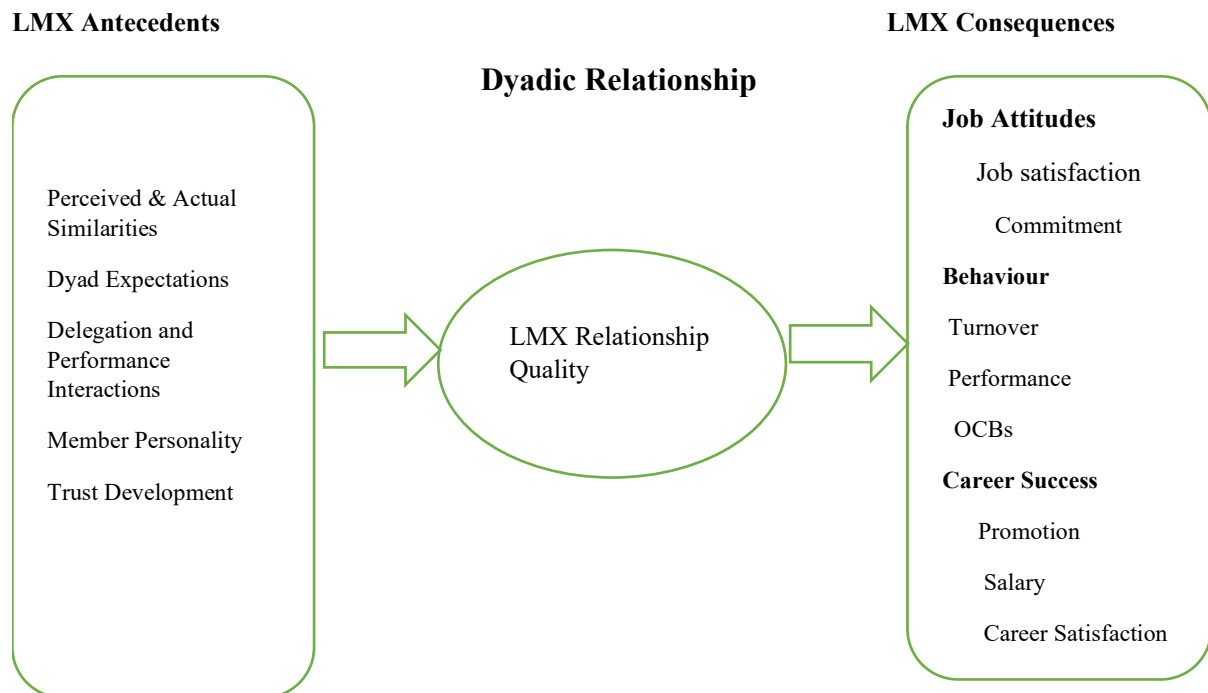


Fig 3.1: **The LMX in relation to its antecedents and outcomes.**

The natural inclination in affiliations and group dynamics is described by the similarity-attraction paradigm (Kacmar, Harris, Carlson and Zivnuska, 2009). The similarity-attraction paradigm is based on presumptions of inclinations due to natural group affiliations involving race, religious beliefs, age, and cultural traits as well as personality similarity traits. It is proposed that this affiliation produces a deep-level similarity that is argued to be a strong predictor of high leader-member exchange relationship (Allison, Armstrong, and Hayes, 2001; Engle, and Lord, 1997; Liden, Wayne, and Stilwell, 1993). A natural tendency and drive exists for familiarity within any social organisation to determine a relationship through the inclination for in-group membership within the organisation. The similarity-attraction theory suggests that members of the same racial backgrounds or other identities forge groups based on attractions to the same values and/or orientations, including managers (Byrne, 1971).

However, personality theorists such as Jenkins (1994) argue that the fundamental attraction toward the managers' in-group and subsequent development of a high-quality leader-member exchange relationship is relative and in most cases is based on employee possession of certain

personality traits. Individual employees can shape events by acquiring a strong quality relationship with the leadership through contributions to the operational effectiveness of the organisation, which are easily noticeable proactive behaviours (Spector, 1982). If an employee demonstrates proactive behaviour by managing his/her own career development plans and showing a stable tendency toward effecting changes in organisations through overt actions, the relationship with managers tends to be relatively positive. Such employees control affairs and easily become part of the decision-making processes through suggestions on work processes (Bateman and Grant, 1993; Mitchel, Smyser, and Weed, 1975; Wu, Paker, and Brindle, 2013). When the individual employee demonstrates the urge to take control of affairs by being assertive and demonstrates the potential for high positions as well as positive affectivity, the person's scope of interaction with members of the organisation, including the manager, will expand. Proactive behavioural traits suggest a contrast with individual employees who are perceived to be presenting self-doubts with non-noticeable signs of taking responsibilities or higher role expectations (Mahsud, Yukl and Prussia, 2010).

In a study of self-citations as a form of proactive behaviours of academics, Deschacht and Maes (2017) found specifically that individualistic-oriented individuals of western backgrounds recorded higher self-citations than those from collectivist cultures. While these attributes could be interpreted to mean proactivity and positive affectivity, it could also equate to self-promoting behaviours that enhance the chances of easy recognition toward individual career development rather than organisational effectiveness. When related to voice in organisations, LePine and Van Dyne (2001) argue that employees' voices are ingredients to encourage initiatives and innovations in organisations.

However, in an examination of voice behaviours in organisations from an impression management perspective, Fuller, Barnett, Hester, Relyea, and Frey (2007) found that employees considered as high self-monitors use voice behaviours to engage supervisors for their personal image building. When applied in this way in organisations, research has also found this to be counterproductive because, in such circumstances, it could promote defensive and protective behaviours and excuses for failures (Rosenfeld, Giacalone, and Riordan, 2002). In a related study that considered employees of both independent and interdependent orientations, Carson, Baker and Lanier (2014) reported mixed findings on reasons for and impact of proactivity behaviours at work by employees. The relationship could positively

determine employees' perceptions of a conducive work environment to guarantee high job satisfaction, reduction in stressors, easy resolution of conflicts and the reduction of intentions to leave the organisation (Burns and Otte, 2006; Erdogan and Bauer, 2015; Rodwell, Noble, Demir and Steane, 2009; Wilson, 2015). It is argued that a corresponding negative effect of poor-quality relationships produces negative outcomes such as lack of trust and lack of job satisfaction, motivation, and well-being (Arnold, Cooper, and Robertson, 1998).

The positive outcome of high leader member exchange relationship suggests that the dyadic relationship could be mutually beneficial to both employees and the organisation. The employee's perception of job satisfaction is as important to the employee as it is to the organisation. As a positive emotional state of an employee because of feelings of the fulfilment of expectations personal and organisational, translates to personal contentment and well-being. According to Warr (2002)'s three-dimensional model of well-being in the context of job satisfaction, the employees' perceptions of job satisfaction is determined by emotions of comfort, pleasure, and enthusiasm.

In contrast, with perceptions of a lack of job satisfaction, employees experience opposite of emotions which include anxiety, displeasure and depression. An organisational environment that increases feelings of satisfaction of employees is argued to be more related to supportive, trusting relationships than toxic ones that characterise an environment of distrust and powerlessness (Warr, 2002). Hackman and Oldman (1975) identified internal factors that determine employees' feelings of job satisfaction including inclusivity through positive interactions with supervisors and peers as well as favourable positive organisational policies.

In perceiving managerial relationships as related to expectations within exchange relationships, research (Morrison and Robinson, 1997) suggests that high-quality leader-member exchange would increase employee-perceived fulfilment of the contract. Leader-member exchange theory is appropriate for understanding employees' assessment of equitable fulfilment of perceived expectations through relationships with their managers (Henderson, Liden, Glibkowski and Chaudhry, 2009).

3.9.2 The LMX Differentiation (LMXD) : Consequences on trust

The LMX differentiation as a group level exchange construct explains the dynamics of exchange relationships which the manager and or supervisor develop with team members. (Henderson, Liden, Glibkowski and Chaudhry, 2009). Zhou and Shi (2014) suggest that leader-member differentiation as an antecedent of organisational relationship conflicts has not been well documented in literature. In the context of LMX differentiation, there is the emergence of social comparison environment (Greenberg, Ashton-James, and Ashkanasy, 2007) with individuals within groups engaging competitively to achieve high quality exchange relationship with the leadership (Wayne and Ferris, 1990).

With emergence of in-groups and out-groups in leader member exchange differentiation, strong group membership could evolve with positive biases only toward own groups based on sex, ethnicity, or any other identifiable features. Power struggles and anticipations of achieving measures of control in restricting or denying and/or providing access and privileges from or to groups become common (Brown, 2000; Buttigieg, Bryant, Hanley, and Liu, 2011). Feelings of high-quality relationship with leadership as well as membership of the ingroup would usually evoke feelings of superiority (Lockwood, 2002), with sentiments and emotions and values of significant importance that could be biased against an opposing group (Tajfel, 1981; Taylor and Lobel, 1989).

The emergence of workplace in and out groups is suggested (Dalton and Chrobot-Mason, 2007; Hogg and Martin, 2003) as possible outcome of differences in ethnicity or social groups. Consistent with the similarity-attraction (Byrne, 1971) theory, there could be greater senses of affinity between the manager and those who share the same identity better than with those who have a social identity mismatch with the manager. This increases the tension rather than reduce it with the other dissimilar or minority groups. The out-group within such social identity power struggles faces intergroup prejudices and is made to feel powerless, hence increasing doubts in self-esteem, avoidance of intergroup interactions, and information processing biases (Essed, 1991; Hodson, Roscigno and Lopez, 2006; Stephan and Stephan, 1985).

Research (Uhl-Bien, Graen and Scandura, 2000; Jehn, 1995) suggest that with increase in LMX differentiation and members' perceptions of disproportionate allocation of organisational

resources, there are corresponding increases in feelings of distrust, inequity and discrimination which is unequal treatment consisting of actions of a presumably dominant group on a subordinate group (Williams, Neighbors and Jackson, 2003). Dalton and Chrobot-Mason (2007) in their evaluation of manager vs employee social identity and conflict management, suggest that a manager's strategy that is perceived to contrast with what is valued by either group runs the risk of creating a trust-deficient organisational environment.

According to McAllister (1995:5), trust "is the extent to which a person is confident in, and willing to act on the basis of the words, action, and decisions of another". The trust school of thought on exchange relationships, argues for the primacy of trust in developing and sustaining high-quality relationships. Trust, as the willingness of one person to be vulnerable to the actions of another (Mayer, Davis and Schoorman, 1995), makes the assumptions that the parties have positive expectations of the actions of the other irrespective of circumstances (Rousseau, Sitkin, Burt and Camerer, 1998). Trust evolves on considerations of competence and benevolence, which incorporates both parties' appreciation of the other's skills, abilities, knowledge, and demonstration of efforts to secure and always safeguard mutual rather than individual welfare and interests (Gabarro, 1978; Larzelere and Huston, 1980).

Trust, in the context of this research would be taken as a construct that consists of cognitive processes as well as affective motivational (McAllister, 1995) dimensions. With elements of trust, employees can determine organisational justice and supervisor support, performance, and employee satisfaction (Burke, Sims, Lazzara and Salas, 2007; Deconinck, 2010; Rich, 1997; Whitener, 1997; Stevenson, 2002; Ronald, Mankind, and Lawrence, 2007). Trust becomes an instrument of managing the exchange relationship when leaders evolve and sustain an environment that promotes psychological safety nets where employees feel confident to generate ideas and be heard without fear of reprisals. This is more cogent when understood from the point of view of cultural differences where issues of personal relationship and social networking take precedence over any other exchange considerations (Gesteland, 1999; Schoorman, Mayer, and Davies, 2007).

In a qualitative meta-analysis of trust in the supervisor-subordinate relationship, Nienaber, Romeike, Searle and Schewe (2014) suggested that antecedents of trust-based manager-subordinate relationships include supervisors' attributes, subordinates' attributes, and organisational characteristics. Organisational characteristics should demonstrate fairness in

policies, procedures, and transparency in practices (Schneider, 1990). In understanding employees' perceptions of actions by managers based on trust, acts of honesty, open communications and principled decision-making processes are argued to increase the positive nature of the exchange relationship (Shanock and Eisenberger, 2006; Villegas and Cerverey, 2004). This also suggests the role of leadership in cushioning effects of conflicts in social comparison within the context of LMX development and differentiation (Brown, Trevino, and Harrison, 2005).

The fundamental and functional moderator to enhance trust levels in a subordinate-supervisor relationship depends on the manager demonstrating acts of genuine care and well-being toward the subordinate (Erdogan, Liden, and Kraimer, 2006; Mayer, Davis, and Schoorman, 1995). Employee perception of organisational support reduces the perception of organisational injustice and, by extension, the intention to leave the organisation is found to be minimal (Costigan, Insinga, Berman, Kranas, and Kureshov, 2011). With managers' or leaders' roles impacting the organisational environment through honest, straightforward communication and interactions, an environment of trust and positive energy evolves (Beck and Hillman, 1992) for harmonious co-existence.

While there has not been a vast amount of research on subordinate attributes that enhance trust relationships with supervisors, there is a consequent response of subordinates exhibiting appropriate attitudes and behaviours that benefit the organisation because of perceived supervisor trust traits (Rhoades and Eisenberger, 2002). Employees who perceive the organisational environment as exploitative, risky, and full of uncertainties are likely to be drawn into actions and behaviours of immediate self-interest (Kelly and Thibaut, 1978). In the absence of effective communication and trust, employees have been found to react and develop perceptions of breaches much more easily and often as they make sense on their own of what is happening between them and the organisation and/or its representatives (Lester, Turnley, Bloodgood and Bolino, 2002).

In a three-year study that examined policy reactions to new performance management systems, Tekleab and Taylor (2003) reported a positive correlation between high-quality leader-member exchange and open levels of communication and perceptions of trust. This process mitigates incidents of perception of the psychological contract breach based on incongruence and links to circumstances of trust because the employee feels the manager is working for and supporting

his/her best interest. The above theories and research support employee-manager trust balance in building a strong and higher LMX relationship.

However, Costigan, Instinga and Berman (2011) in their study involving workers in USA, Russia, Poland, and Turkey on trust building and relationships, reported that the strength of a relationship is positive in a high-power distance culture when based on an affect-based model of trust building. In high power distance societies, Doney, Cannon, and Mullen (1998) argued that employees were drawn to positions of power and capabilities of leaders to form strong foundations of their trusting relationship. Perceptions of power and status differences not only moderate high trusting leader member relationship but also of the co-worker relationship (Van der veegt, Van de vliert, and Huang,2005).

Spector and Jones (2004), in a survey study of 127 professional-level employees working in industries, argue that hierarchical relationship may not be conducive for trust building. The study argues that, instead of forging close trust relationships, the gaps in interactions that high status demarcation creates could impact communication and consequent feelings of distrust. This is in contrast to low distance societies which presupposes an egalitarian sense of relationship with narrowed gaps in the way people communicate and interact without considering statuses and qualifications of either managers or co-workers.

Section summary: In the review, while it is noted that exchange relationship between the manager and the employees could enhance positive evaluation of subjective expectations, theoretical concepts such as perceived organisational support, organisational justice and leader member exchange and its group construct of differentiation, have a lot to offer in understanding perceptions and dynamics of exchange relationships in organisations. The exchange relationship outcomes could determine both employees' well-being at work and the effectiveness of the organisation, given key aspects of expectations and obligations of the employee to the organisation. Most important, the review positioned the manager as a very pivotal link in exchange relationships and interactions .

The review highlighted the functional relationship between the manager and the subordinate and how it could impact organisational outcomes and perceptions. The present research relates to an extent on the interactional relationship of West African migrant nurses regarding their perception of the actions and behaviours of their managers and colleagues at work.

The review highlighted the nature of exchange relationship in respect of the leader-member exchange (LMX) theory and how this could be developed and more fundamentally its concept of differentiation and how this could impact on perceptions and relationships at work. The reviews and lessons previous research findings on relationships suggest that nurses are likely to engage in evaluating their exchange relationships at work and how these advance the realisation of their expectations. The exchange relationship theories and concepts, as reviewed, presented an overview of the possible nature of relationships which West African migrant nurses might anticipate as part of their overall work experiences.

The review of literature on exchange relationship theories and concepts highlighted the nature and essence of employee manager relationships at work. The review also established the human behavioural aspects of the relationship regarding the quality and implications of the relationships.

Chapter 4: Perceptions in organisations and cultures

In the following review on the construct of perception, the researcher examines antecedents of making sense of actions and events in forming and engaging in relationships, especially at work. In doing this, the researcher also reviews concepts of culture and other values which could have subjective impact on sense making within circumstances.

According to Bratton, Sawchuk, Forshaw, Callinan and Corbett (2010), perception has become an influential concept in contemporary organisational behaviour studies. As a cognitive concept within organisational behaviour, perception is a retrospective process which draws on previous experiences and beliefs to evaluate current experiences (Meyer and Allen, 1991; Salancik and Pfeffer, 1978; Rollinson, Broadfield and Edwards, 1998). It relates to employees' cognitive subjective processes and involves their understanding, interpretation, and responses to organisational dynamics, including actions and behaviours of colleagues and management (Maitlis and Christianson, 2014; Weick, Sutcliffe and Obstfeld, 2005).

Figure (4.1) below shows the perception processes that outline the possible means through which signals are picked up and processed either through available cues or possible existing knowledge, motivation, and expectations, hence its subjective foundations.

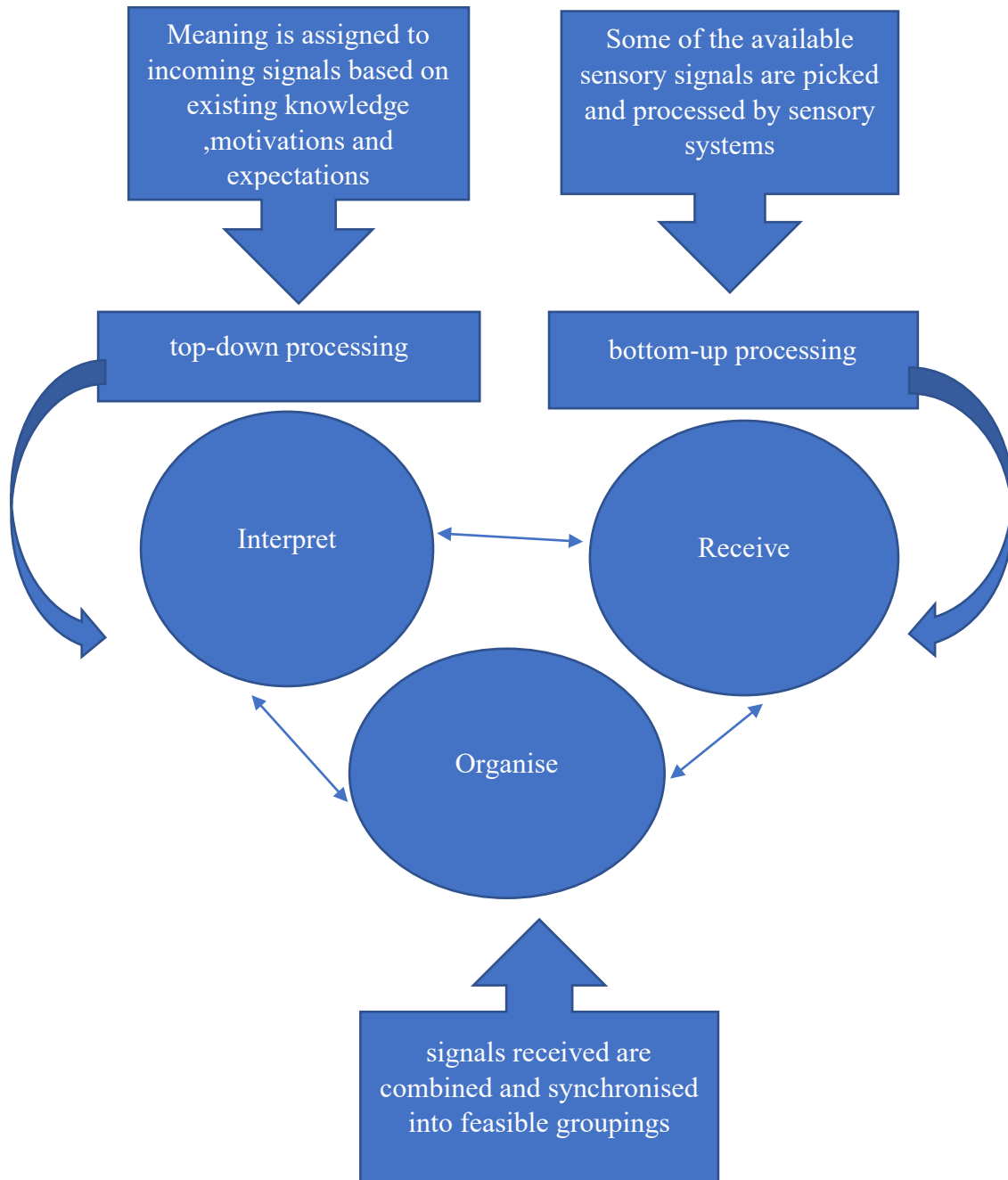


Fig (4.1) Elements and processes of perception showing how the understanding of events and actions could evolve (culled from Bratton, Sawchuk, Forshaw, Callinan and Corbett, 2010:135).

4.1 Subjectivity of perceptions

Generational groupings in organisations may have different perceptions of events, actions and/or behaviours (Cennamo and Gardner, 2008). The subjectivity of outcomes of perceptions, therefore, relates to how human judgments are made amid different possible realities (Bratton, Sawchuk, Forshaw, Callinan and Corbett, 2010). In the context of perception, the interpretation and meaning given may not represent objective reality as this could be socially constructed or the outcome of existing schema or knowledge. However, it does not matter whether such understanding or interpretation is rational or not, it has been found to impact on human responses and behaviour within the circumstance. In separate research, Chinese managers' warm relationships for instrumental and emotional reasons with their subordinate employees were found to have been perceived as fair in their treatment by their subordinates (Osigwe and Huo, 1993; Tsui and Farh, 1997). The employees' perceptions of fair treatment consequently contribute to the employees' positive relationship with their managers (Lind and Tyler, 1988).

4.2 Perceptions in organisations

Organisational justice processes involve employees' evaluation of distributive, procedural and interactional organisational dynamics. Through this process of evaluation, employees make judgments about the allocation of resources and fairness of the processes as well as the nature of interpersonal relationships built on respect, honesty, and sensitivity to their personal needs (Bies and Moag, 1986; Colquitt, 2001; Colquitt, Conlon, Wesson, Porter and Ng, 2001; Lewis and Zibarras, 2013). In an organisational setting, the risk of misinterpretation or biased perception brings employees to adopt reality check approaches to mitigate expectations and perceived realities through the interpretation and evaluation of events and attaching meanings, especially when there is a perceived sense of existing ambiguity (Weick, Sutcliffe, and Obstfeld, 2005).

According to Mowday, Steers and Porter (1979), an employee's demonstration of organisational citizenship behaviour is positively related to the employee's perceptions of being treated fairly, rewarded, and trusted to perform tasks and achieve self-efficacy. Employees' perceptions of valued contributions and application of their skills and knowledge moderate high task performance and reduced intentions to quit organisations (Eisenberger, Huntington, Hutchinson, and Sowa, 1986). When an employee perceives that organisational

goals are consistent with his/her own goals, scholars (Eisenberger, Armeli, Rexwinkel, Lynch, and Rhoades, 2001) suggest an increase in extra role behaviours. Such perception is likely to reduce counterproductive role behaviours and increase the exhibition of organisation citizenship behaviours.

In the performance of assigned tasks, scholars argue that employees' feelings of being trusted, valued, and supported by managers and co-workers drive a sense of self-direction and guide task and contextual task completion (Meyer and Allen, 1984; O'Reiley and Chatman, 1986). Similarly, employees' sense of organisational self-esteem is driven by the consideration of the self as a valued member of the organisation whom management and others feel can make vital contributions to the organisation (Pierce and Gardner, 2004). However, in making contributions to the organisation, an employee engages in evaluations of fairness in the management's allocation of tasks offering tools and incentives in dealing with stressful situations.

In a quantitative cross-sectional study with healthcare employees in South Africa, Coxen, Van and Stander (2016) found, however, that there was no significant relationship between an employee's trusting relationship with managers and organisational citizenship behaviour. However, their findings were faulted or limited by the fact that their study participants did not have a direct work relationship with their managers but with team leaders whom they considered as co-workers and therefore had no expectations of directions and patronage. This finding suggests that employees make sense of the relationship from their preconceived norms that support close relationships with their managers. The implication of the study finding is that if employees have direct contact with their managers who they expect to build a bond with, the relationship would be positive given their background expectations of paternalistic care based on their perceived status of their managers.

While the above research suggests a cultural aspect of employees' relationship with their managers, Walumbwa, Avolio, Gardner, Wernsing and Peterson, (2008) argue that as a general norm, there is of a positive correlation between employees' perceptions of their manager demonstration of an authentic leadership style of balanced processes and relationship

transparency and their feelings of job satisfaction and their subsequent demonstration of organisational commitment.

West African migrant nurses, given their different backgrounds in training and previous experiences at work in home countries may be inclined to judge events and actions in their relationship with their managers and colleagues from different perspectives. Iwowo (2015), suggests that leadership practices in Africa have been shrouded with criticisms of being dominated by western leadership constructs. Such ingrained feelings could create suspicion between the nurses and their managers as well as co-workers.

While recognising the sensitivity of indigenous values in management practices and implications on cross-cultural management, Iwowo (2015) therefore argued for a hybrid leadership consideration within the context of engaging mainstream theories, and indigenous knowledge for reflective organisational leadership practices. This is to project an authentic leadership environment of fairness and transparency, leading to a trusting relationship between not only the managers but also with co-workers. This trusting environment will enhance employee performance and ability to acknowledge mistakes but also the willingness to learn for organisational effectiveness (Avolio and Gardner, 2005; Lencioni, 2005; Wong, Laschinger and Cummings, 2010).

4.3 Perceptions and cultural conceptions

Culture in the context of this research refers to national or societal cultures as opposed to organisational cultures. There is no consensus on the actual definition of culture. However, culture involves systems of values, attitudes, beliefs, and behavioural meanings that members of a given society share and transfer through generational learning (Thomas, Au and Ravlin, 2003). It consists of passed-on values, customs, rituals, and symbols shared by people within a nation (Alder and Gunderson, 2008; Peterson and Smith, 1988). In a symbolic expression of culture, Hofstede (1991) identifies it as the collective programming of the mind capable of distinguishing the members of one group or category of people from another. Symbols of culture provide common issues of absolute connotation which members of the group hold for themselves through generational transfers to them in their daily interactions and dealings among themselves and with outsiders.

Culture as learned and shared values of societies impacts the behaviour of a people within given societies (Koester and Lusting, 2013; Pheng and Yuquan, 2002) with such beliefs, values, norms, and social practices serving as yardsticks for the group to determine what is supposed to be right or wrong and what issues are acceptable as a behavioural way of life. Culture therefore relates to values that are patterned for the co-existence of the group and used to determine norms of observable activities and interactions (Markus and Kitayama, 2010).

Perceptions and expressions of emotions are human and tend to determine an individual's well-being and nature of interpersonal relations and communication (Johnson, 1997). According to scholars of cross-cultural psychology, while emotions of happiness, sadness, surprise, disgust, anger, and fear could be universal in their expressions, variations exist in relation to an individual's cultural upbringing (Ekman, Friesen, O'Sullivan, Chan, Diacoyanni-Tarlatzis, and Heider, 1987; Shioiri, Someya, Helmeste, and Tang, 1999). Research by Iwata and Buka, (2002) found differences in sense making of circumstances and phenomena as well as in expressions of mood as a result of differences in schemas and built-in blocks of values. Schemas constitute a knowledge domain that influences perception and behaviours applied in ascribing meanings to situations and circumstances (Huczynski and Buchanan, 1991; Friedman and Antal, 2005). As a result of these schematic differences, communication among organisational players from different value backgrounds could be emotive in the content of speech, tone, facial expression, body language, gestures, and assumptions (Trompenaars and Hampden-Turner, 2003).

While some cultural values would emphasise direct communication to get messages across, others use would adopt indirect cues and nonverbal expressions to advance their thoughts and actions (Hall, 1976). For instance, nonverbal gestures and physical elements of embracing and hugging are given different meanings by different people within the organisations. While some persons or groups of persons may construe direct eye contact as disrespectful, others may see it just as a normal display of confidence (Gudykusk, 1994). In their study which examined USA and East Indian young adults' perceptions of intergenerational communication, Giles, Dailey, Sarkar and Makoni (2007) found that avoiding direct (face to face) communication with the elderly, which was considered act of respect, offered satisfaction to the younger generation. Similarly, respect at the workplace has been found to be age- and status-dependent

in some cultures. Some cultures embrace closer and more intimate body contact, especially when exchanging pleasantries, while others would view them as encroachments within personal spaces and offensive. In situations such as described, communication of the virtues of respect becomes complex and ambiguous because of the variations in cultural perceptions of what constitutes respect (Rogers and Lee-Wong, 2003; Thorne, Harris, Mahoney, Con and McGuinness, 2004).

In a study of negotiating organisational communication cultures in American subsidiaries doing business in Thailand, Stage (1999) found that while lower-level employees in Thailand shied away from direct communication with senior managers, they aimed to maintain strong relational bonds with their managers. However, face to face communication should be differentiated from conveyance of message meanings by other channels. While some cultural values emphasise direct communication to get messages across, others use adopt indirect cues and nonverbal expressions to convey their thoughts and actions (Hall, 1976). Western societies, including the United Kingdom, convey direct verbal messages whereas, Afro-Asian countries, use indirect, non-verbal, and internalised processes with pronounced use of kinesics involving body languages and gestures (Trompenaars and Hampden-Turner, 2014).

Lack of understanding of cultural values sensitivities have been found to cause deep conflicts between indigenous peoples and visiting foreign tourists with different cultural conceptions. In a study involving indigenous peoples of protected areas of the USA, Australia, and New Zealand, Zeppel (2010), reported a strong rift between the indigenous people and visiting tourists over their presence in areas considered sacred. While the tourists find hiking in some areas fascinating and of recreational value, the indigenous people resisted activities around the rocks and mountains which they considered sacred and of spiritual significance. These findings highlight the practical implications of how understanding value differences can enhance relational interactions and reduce strained relations in organisations (Simon, 2007). Scholars argue that achieving effective communication under the circumstances involves the mutual commitment of all players and groups (Cole, 1990; Hofstede, 1991; Jahoda, 1984). However, communication difficulties in multicultural organisations may not necessarily be the result of the cultural distance between the groups but rather are the result of the conscious choice by players to maintain their own values to achieve strategic categorisation (Anderson, 1990).

When one's own cultural values become instruments of power domination, it is usually when cultural styles of communication are projected as signifiers and emblems of national identification with the intent of benefiting from its power intrigues associated with individual positioning and group making (Lawrence, 2004; Vaara, Tienari, Piekkari, and Santti, 2005). In the circumstances, the dominant group is usually determined to keep its communication styles intact by deliberately building barriers making cross-cultural communication difficult. According to Druckman, Broome and Korper (1988), when two or more values collide, divergent preferences emerge with the inevitable consequences of conflict. This is because of the differences in individuals' perceptions and judgment (Harrison, 1980).

Scholars of cross-cultural organisational conflicts differentiate the natures of conflicts that occur within organisations to include tasks, relational, emotional, and interpersonal conflicts. However, relational conflicts would occur because of perceptual differences and misunderstanding the actions /or behaviours of the other person and/or group. This is more likely to involve differences in values. With learned and built-in conceptions, cultural values are coded into schemas that are applied in a predetermined patterned way of thinking in reacting to current actions and behaviours (Earley, 2006).

In managing issues of relational nature involving value differences, Early and Ang (2003) theorise about engagement through cultural intelligence, which is a cognitive skill and the capability to function and manage within multicultural environments. There is an individual demonstration of high-level desire, interest, and energy to appreciate cultural adaptation in different or varying cultural settings. According to Van Dyne, Ang, Ng, Rockstuhl, Tan, and Koh, (2012), cultural intelligence is an individual's determined development of capacities of metacognition, cognition, motivation, and behavioural cues to engage within cultural diversities. This would involve an individual's determination to detect, assimilate, reason and act on cues of cultural differences (Sternberg, 1986). In a study, Ramsey, and Lorenz, (2016) found a positive relationship between conscious acquisition of cultural intelligence and job satisfaction and commitment. This was the result of the deliberate actions of having knowledge about cross-cultural values and getting practically flexible in engaging in the context of acquired knowledge. The skill of cultural intelligence (CQ) provides the motivation needed to sustain energy to pick the knowledge and behaviour based on that knowledge rather than what the person ordinarily thinks (Sternberg, 1986). In that case, cultural intelligence builds on the

motivation to engage and the behaviour to act through adjustment of mental models during socialisation and interactions (Brislin, Worthley, and MacNab, 2006).

In a study, Chua, Morris, and Mor (2012), found managers with higher metacognitive cultural intelligence reported higher creativity in performance and sharing of ideas than those with lower metacognitive cultural intelligence in multicultural organisational settings. Most common issues of organisational conflict develop from limited social integration skills and cultural intelligence (Gudykuns and Nishida, 2001). In a study, Peltokorpi (2006) found that differences in understanding each other's work values led to misconceptions and miscommunications between Japanese employees and their Nordic expatriate managers. The local natives interpreted and perceived the actions of the foreign managers as non-conforming to their known values and consequently isolated themselves from the managers. Other studies Alsar, Shahjehan, Shah and Wajid (2019) and Jiang et al (2018) that examined transformational leadership and cultural intelligence as an antecedent of voice as well as the mediating role of leader-member exchange found that migrant employees with high cultural intelligence also engage in voice behaviours which contribute to effective adaptation.

Given that contemporary organisations are homes to different employees from different nationalities with divergent interests and value-laden expectations, differences in perceptions and behavioural responses are observed constantly (Fischer and Smith, 2006; Markus and Kitayama, 1991; Thomas, Kevin and Ravlin, 2003). As subjective as perceptions are, they influence actions and reactions in organisations (Trompenaars and Hampden-Turner, 2014). Cultural value differences can influence how organisational players shape and inform thoughts as well as attach meanings to actions and behaviours (Markus & Kitayama, 1991; Stewart and Bennet, 1991; Taggar and Haines, 2006). In attributions, cultural norms and values are unconsciously applied in evaluating organisational processes' actions and acts to determine what constitutes fairness or otherwise of the system (Erez and Earley, 1993; Kastanakis and Voyer, 2014; Scollon and Scollon, 2001).

4.4 Migrants: cultural conceptions and destination adjustments

Migrants as social groups who move from one distinct culture to another respond to situations and circumstances in ways that mitigate the impact of their experiences. International migrants experience unfamiliar ways of life in host countries because of the cultural distance between them and the host communities. This situation can make the migrants disoriented or confused, creating states of cultural shock and environmentally induced stressors (Furnham and Bochner, 1986). It becomes inevitable that social beings attempt to adapt in such unfamiliar situations. Literature and research suggest that options available to migrants in managing such situations depend on cultural influences and expectations (Berry, Poortinga, Segall and Dasen, 1992).

Acculturation as an adaptive strategy, is a dual process of cultural and psychological change involving individuals and groups from different cultures. These changes occur at affective, behavioural, and cognitive dimensions (Berry, 1997; Berry, Poortinga, Breugelmans, Chasiotis and Sam, 2011). According to Graves (1967), acculturation occurs at different rates both at the individual level and the group level. It is possible for individual migrants from the same native ethnic background to embrace acculturation in their new environment in different degrees (Furnham and Bochner, 1986). Large (1989) also suggests that the degrees of embracing new cultural values vary across generations of migrants. It is much easier for more recent generations of migrants to adapt to embrace host nations' values than older generations.

The anticipated length of stay in a destination country by migrants also often leads to a high degree of effort toward acculturation (Berry, 1997; Cameron and Lalonde, 1994) as well as a strong personal sense of determination to engage and socialise by new entrants to a new cultural environment. The implication of this finding may indicate that West African migrant nurses who anticipate a long stay in the United Kingdom may be more likely to engage with their host country cultural expectations. In their study of perceptions of workplace bullying, Loh, Restubog and Zagenczyk (2010) found that migrant employees of Australian origin were more overtly reactive to circumstances of bullying than their Singaporean counterparts. The explanation for this was given as reflecting the circumstances of their cultural conceptions on the backgrounds of low and high-power distance cultures. This further explains the relationships between perceptions and responses to organisational interactional dynamics and conceived cultural values. The Singaporeans' responses seemed not to have been oversensitive to manifestations of acts of bullying because of their cultural background of tolerance of

managers' use of power and authority. On the other hand, those from Australia, with low power distance cultures were found to respond and challenge high handed approaches perceived as bullying.

To feel a sense of belonging in the USA, Hispanic migrants avoided noticeable ethnic-oriented actions to embrace the host community's values (Chattaraman, Lennon and Rudd, 2010) as part of an intense drive to acculturate. Some migrants, therefore, tend to embrace their host countries' cultural norms and values much more quickly than others. However, sometimes, migrants are caught in between socio-cultural conflicts because of social pressures to embrace their destination country's cultural norms (Penaloza, 1994). The resultant effect would be experiences of conflicts in resolving social-cultural identity crises as they consider whether to embrace the new culture or to retain own cultural identity. The implications of the above research findings on migrant employees and cultural adjustments regarding the present research, could infer that West African migrant nurses, because of individual differences, may vary in the extent to which they may adjust to cultural expectations of their host culture.

4.5 Migrants: Acculturation and work wellbeing

In examining job satisfaction, work wellbeing and standard care delivery, Nolan *et al*, (1995) reported that nurses' feelings about their ability to deliver good patient care within positive co-worker relationships predicted their perceptions of job satisfaction. Similarly, Lee *et al* (2003) who studied models for predicting burnout in Korea, found that work overload, shift patterns and conflicts in interpersonal relationships impacted on the nurses' perceptions of job satisfaction and wellbeing. In the context of migrant relationship and wellbeing at work, research suggest that these can be predictable. Chinese migrant nurses who resisted acculturation and insisted on maintaining their original traditional values experienced low levels of job satisfaction when working in a different country (Goh and Lopez, 2016). This was attributed to differences in their expectations and the nurses' reluctance to accommodate the host country's cultural values which subsequently led them to experience dysfunctional organisation interpersonal and social relationships.

However, Paswan and Ganesh (2005) found no direct negative consequences for some migrants on who continued to connect with ethnic roots to maintain home cultural identities and therefore do not respond or embrace the values of their new environment. While the migrants continued to work, they maintained degree of continued affiliation to native values irrespective of pressures and influences of destination country cultural values.

Erinle and Agbayani,(2007) claimed evidence to suggest that migrants who were determined to embrace and assimilate within the new cultural work setting, were more able to get support at work and less likely to report low job satisfaction. However, in the context of a globalized and diverse workforce, understanding cultural issues for both cross-cultural management and engagement effectiveness go beyond both management and employees' simple awareness of cultural differences. Brunton and Cook (2018) in their study of migrant nurses' management of communication difficulties in their new work environments, the study found the nurses willing to adapt to fit into the system but Earley and Ang (2003) argue that the specific development of capabilities and personal energy to drive cultural intelligence (CQ) is necessary to support effective organisational interactions and interpersonal relationships.

4.6 Dimensionalising cultural values

The cross-cultural management school of thought is concerned with the influence of cultural value differences on organisational processes and behaviours such as in the use of authority, perception of self and conflict resolution (Inkeles, 1997; Kluckhohn & Strodtbeck, 1961). Cultural frameworks guide the understanding of the common-sense assumptions of a society and distinguish a culture from other cultures (Ogbor, 1990). Cultural frameworks or dimensions represent the ordering of societies according to the way they deal with affairs either as individuals or collectively (Hofstede, 2011).

In determining value differences, writers have suggested categorizing these as cultural typologies and/or dimensions. However, there is no consensus on these typologies, for organisational research and management purposes. These variations in conceptions of how cultural values might be categorised and grouped have informed the application of different models and dimensions, including the Hofstede's dimensions. Models or dimensions of cultures that have appeared in literature and research include the Kluckhohn and Strodtbeck,

(1961), (Hofstede, 1980; 1991), Hall (1981;1990), Trompenaars and Hampden-Turner (1998), Schwartz (1999), and GLOBE models (2004)

4.6.1 Kluckhohn and Strodtbeck (1961)

This earliest study had an important influence on later theories on cultural models. The Kluckhohn and Strodtbeck cultural model was the outcome of a study testing five value dimensions within district societies of the American Southwest, in Hispanics and Anglo-American estates areas (Nardin and Steers, 2009). The model distinguished values about the considerations of relationship with nature, relationship with people, human activities, relationship with time and human nature. While Kluckhohn and Strodtbeck (1961) mentioned value dimensions such as collaterality and individualism, the study was not intended to be applied to other parts of the world.

4.6.2 Hall (1981, 1990) model

The Hall model was based on ethnographic research on German, French, American, and Japanese societies. The model produced outcomes about how societies are differentiated on issues such as interpersonal communications, personal space, and time. This informed understanding of how messages in forms of communications could be coded in different societies either directly or indirectly. Hall's cultural typology identified the contexts of message values described as low and high context cultures. According to Lustig and Koester (2013), in high context cultures, members internalise values, norms and social practices. Messages in high-context cultures lay emphasis on non-verbal cues and indirect, meanings of the messages which occur naturally to others in the in-group. The collective understanding of the non-verbal, indirect but meaningful messages promotes harmonious relationship and interpersonal bonds amongst members of the in-group. On the other hand, low context cultures, have partly coded but mostly explicit messages which pass on exact meanings and expectations so that the interpretations are unambiguous and direct.

4.6.3 Schwartz cultural model (1992;1994)

The Schwartz cultural typology drew inferences from previous models such as the Kluckhohn and Strodtbeck on grounds of individuals and groups relationship and boundaries (Lustig and Koester, 2013). The individual value constructs across societies were conceptualised into seven values of embeddedness, hierarchy, egalitarianism, mastery, harmony, affective autonomy, and intellectual autonomy. This model distinguished individual cultural value motivation and group cultural value motivation which place values on motivation for individual independent thoughts and ideas for creativity and innovation and achievement of communal goals and social relationships, respectively. According to Bond (2001), while the Schwartz model has been applied to understand individual human behaviours within social environments, it has less relevance in organisational research.

4.6.4 Trompenaars and Hampden-Turner model (1998)

The Trompenaars and Hampden-Turner cultural model, followed a ten-year study on Shell and managers from different countries with outcomes that suggested consistency with Hofstede's earlier dimensions. This model, however, identified seven dimensions; including universalism vs particularism, individualism vs collectivism, specific vs diffuse, neutral vs affective, achievement vs ascription, time perspective and relationship with environment. Trompenaars cultural value dimensions have been argued to be limited in scope and coverage around the globe with regards to country-specific scores and analysis (Smith, Peterson, and Schwartz, 2002).

4.6.5 House, Hanges, Javidan, Dorfman and Gupta (2004) GLOBE model

The global leadership and organisational behaviour (GLOBE) study represents the most recent efforts in differentiating cultural values, using data from 62 countries to understand leadership effectiveness processes across cultures. In addition to a few added issues, the GLOBE study incorporated previous works on values such as Hofstede's individualism vs collectivism, power distance and uncertainty avoidance as well as Kluckhohn and Strodtbeck cultural typology. This study therefore still reflected much of the findings of Hofstede's earlier studies without adding much to our understanding of cross-cultural issues (Hofstede, 2010).

4.6.6 Hofstede's cultural dimensions (1980; 1991)

Hofstede's earliest theory of cultural dimensions (1980) was an outcome of collected and analysed data from 116, 000 survey questionnaires administered to IBM employees from 72 countries (Minkov and Hofstede, 2011). The country-level correlation analyses produced evidence for national value dimensions of power distance, uncertainty avoidance, collectivism/individualism, and masculinity/femininity with the later addition of long-term orientation which further explains norms, beliefs, and self-descriptions (Minkov and Hofstede, 2011). Even though Hofstede's study came after Kluckhohn and Strodtbeck (1961) study, it was influential in establishing research into cultural differences and created a popular understanding of how countries might differ with his assumptions that individuals have inbuilt "software of the mind" based cultural values (Lustig and Koester, 2013).

Hofstede's theory on dimensions of culture suggested insights to grasp the complexity of national cultural differences. Hofstede's dimensions suggest how nations and societies manage and respond to issues based on individualism-collectivism, power distance, uncertainty avoidance and masculinity-femininity (Hofstede, 1980). In the synthesis of studies on cultural dimensions, while differences are observed some common issues emerged in their arguments. Some of these common issues involved the priorities of the self and group (Schwartz's autonomy and embeddedness, Hofstede's individualism and collectivism, Hall's low and high context) and the balance between social classes (Schwartz's egalitarianism and hierarchy, Hofstede's power distance and masculinity and femininity).

Fig 4.2 below shows Hofstede's original four cultural dimensions.

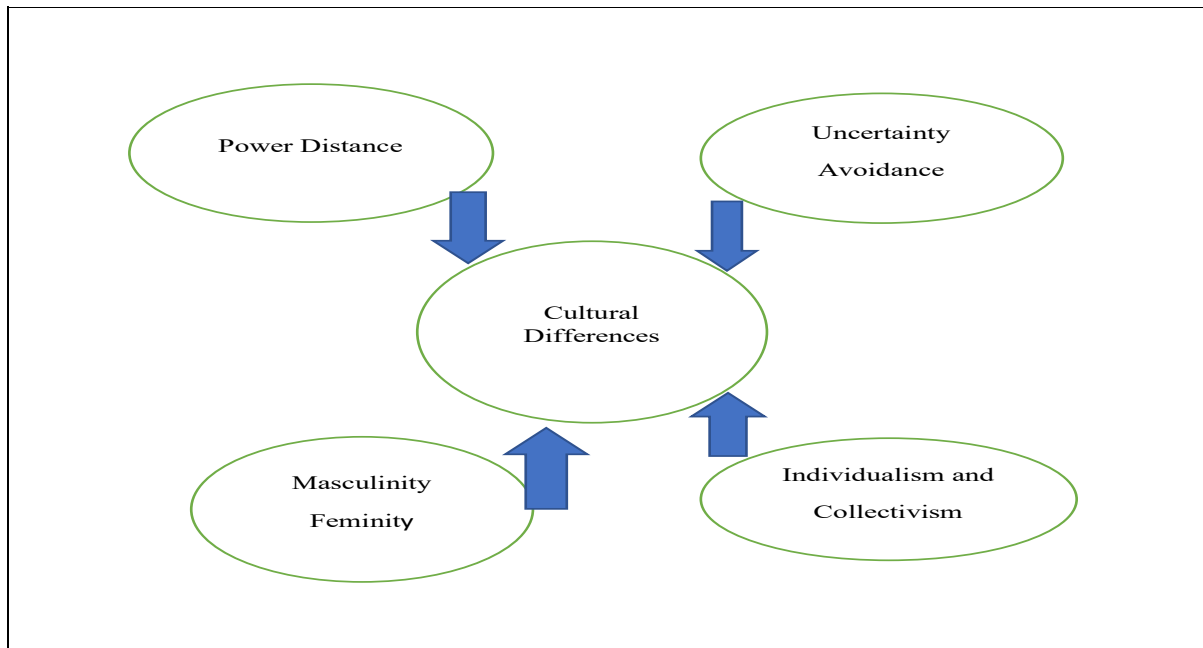


Fig (4.2): Showing Hofstede's cultural dimensions of power distance, individualism and collectivism, uncertainty avoidance and masculinity-femininity

4.6.6.1 Individualism vs collectivism (IDV-COL)

The individualism vs collectivism cultural dimension considers the interplay of harmonious relationships versus the pursuit of individual interests within members of the society. In high individualistic cultures such as the United Kingdom and the USA, the individual members of the society value a sense of autonomy, independence, and personal accomplishments (Lustig and Koester, 2013). It relates to the level at which members of the society maintain independence and the sense of a loosely knit social framework (Triandis, 1995). In high

collectivistic cultures such as West Africa and Indonesia on the other hand, there is a value pattern of collectivism, group loyalty and support that makes for a strong cohesive in-group. The close social framework enhances group goals and processes of decision making.

There is the feeling that the individuals see themselves as integral parts of the in-group within any family or corporate settings (Triandis, 1995). There is a long-term moral obligation of individual members to the group which fosters a strong attachment and defines the existence of members (Triandis, 1988). The notion of collective responsibility holds for everyone, with every member protecting the sanctity and harmonious relations that exist within the group (Hui and Triandis, 1986). This protects the group identity with the group demanding and expecting loyalty from its individual members. In societies high on collectivism, stability of values helps to support appreciation of values such as humility to authority and power as well as the concept of the wisdom of the elders (Fischer et al, 2010) which bestows respect on them, whereas in individualistic value societies, intellectual freedom and broadmindedness provide less support for traditions.

4.6.6.2 Power distance (PD)

The power distance dimension suggests the extent to which people manage and accept power relationships and distribution (Doney, Cannon, and Mullen, 1998). This measures the interpersonal power or influence relation at work and the unequal distribution of power and authority (Hofstede, 1991). According to Rodrigues and Blumberg (2000), socialisation within and from high power distances accepts power centralisation strategies. In such a case, the exercise of power and authority forms the foundations of support from the superior (Carl, Gupta and Javidan, 2004). While it could be common to challenge actions and maintain lateral communication structures through reductions in hierarchical structures among low power distance cultures, it would be uncharacteristic not to have a controlling figure from the top to ensure guidance and direction in high distance cultures (Ueno and Sekaran, 1992).

According to Lustig and Koester (2013), the impact of power distance which a society adopts is observed in relationships between students and teachers, family customs and organisational practices. In each of these cases in high power distance cultures, leaders and or managers are expected to appropriate power and authority in whichever way they desired but should also be available to provide guidance, supervision and support to the led members of the group. In

societies with high power distance, the leader possesses bestowed instruments of authority with expectations of reverence from followers (Hofstede, 1991; 2011). Expectations are that the manager or leader assumes the role of the “benevolent autocrat” with its attendant emotional attachment in the relationship between the managers and subordinate. Hence employees of collectivist and high-power distance backgrounds value genuine shows of concern by their managers and reciprocate positively through quality work outcomes (Konrad and Deckop, 2001). In a study, Choi et al (2019) found that expectations that migrant nurses would be easily conversant with organisational practices in host countries could be misplaced because of hegemonic difficulties in the nurses’ negotiation of acculturation against their previously and deeply held beliefs.

4.6.6.3 Uncertainty avoidance (UA)

According to Hofstede, the uncertainty avoidance dimension is an assessment of how members within a culture feel threatened by ambiguous or unknown circumstances or situations and the level of involvement with uncertain and risky adventures. The cultural dimension of uncertainty avoidance suggests that societies vary in ways they tolerate and manage conflicts and ambiguities. When situations present as ambiguous, cultures that are highly oriented to uncertainty avoidance attempt to avoid risk taking. There is an obvious preference for predictable, less complex, and ambiguous environments which procedures and rules can guarantee. According to Hofstede (2011), low uncertainty avoidance cultures can tolerate uncertainties within ambiguous environments as much as they are able to tolerate deviant behaviours that may challenge rituals and rules. Whereas in the high individualistic and low uncertainty avoidance societies, individual members engage in confrontational approaches in managing interpersonal issues, high collectivistic and uncertainty avoidance society members would opt into avoidance, third party mediations and face-saving approaches in managing conflicts

4.6.6.4 Masculinity-femininity (MAS).

The Hofstede's cultural dimension of masculinity -femininity explains the predisposition of a society to embrace the belief in assertiveness, competition, and gender egalitarianism. Hofstede used masculine and feminine to mean that society could be characterised by typically masculine characteristics, like assertiveness, or typically feminine ones like being caring. For instance, Soares and Shoham's (2007) illustration of the dimension is that in high masculinity cultures, achievement and success are dominant values while high femininity cultures are characterised by caring for other and quality of life values. While few other characteristics have been used to rationalise this dimension, Hofstede's earliest study suggests that high femininity cultures promote less prescriptive roles for both sexes, whereas low femininity cultures promote sex role socialisation through which the female folk are indoctrinated into traditional social constructed feminine roles. These roles are differentiated from the dominant male roles

Fig 4.3 (below) shows Hofstede's cultural dimensional differences between the United Kingdom and West Africa. Note "Waf" as coded indicates West Africa and "UK" indicates the United Kingdom. The dimensional differences are shown in scores of measurements.

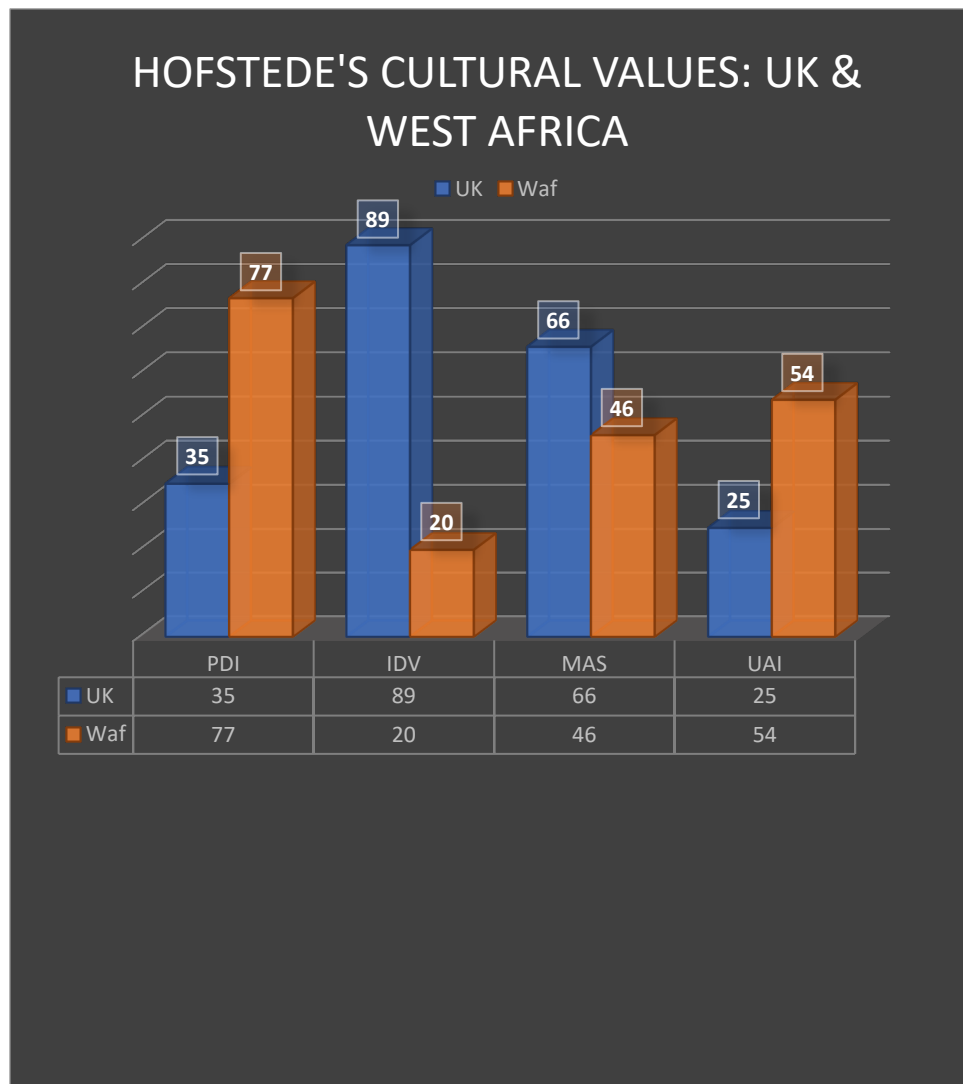


Fig 4.3: Hofstede's dimensions mapping cultural values of the United Kingdom and the West Africa([http://geert-hofstede.com/west Africa](http://geert-hofstede.com/west%20Africa); see also Hofstede, 1991)

The scores on Hofstede's cultural dimensions, as shown in Figure 4.3 above, suggest value differences between West Africa as a geographical region and the United Kingdom. West Africa has a reported marked difference under power distance with a high score of 77 while the United Kingdom has a score of 35. In his assessment of the power and authority distribution of West Africa, Hofstede reported a high-power distance environment with a score of 77, which he suggested indicates a societal cultural orientation which the people accept hierarchical order on power and authority as well as differences amongst social classes. This contrasts with societies like the United Kingdom, with a low power distance (LPD) score value of 35. In this

cultural orientation, it is considered normal for subordinates to be assertive to challenge decisions of authorities within the context of minimal social class distinctions. This value orientation supports an understanding that both the manager and the subordinate share an existential equal relationship and the manager is considered easily accessible through lateral levels of communication (Hofstede, 2011). On individualism, the United Kingdom has a score of 89 while West Africa recorded a low score of 20. In Hofstede's assessment of West Africa based on this culture dimension, the zone scores a low value of 20, which suggests a collectivist society with a strong attachment and commitment of the individual members to group membership.

In their study, Thomas and Ravlin (2003) found that individuals from collectivist-oriented backgrounds are less overt in expressing expectations of direct, immediate rewards for contributions of efforts. This explains the high threshold in perceptions and considerations of equity on material and tangible rewards but high sensitivity to interactional and relational aspects in work relationships. Eaton and Louw (2000) suggest that African students applied a high degree of social responses in describing themselves, which is more consistent with collectivist values than with English-speaking students. The study indicated distinct values characteristic of indigenous African students.

Hofstede's assessment of West Africa suggested a high value of 54 for uncertainty avoidance indicating a degree of cultural orientation to avoid uncertainties while accepting more of structured and clear set of guidelines and standards. This contrast with the United Kingdom's relative low value of 25. According to Clark (1990), Hofstede's dimension of high uncertainty avoidance drives people's adherence to actions of mitigation to avoid incidents and actions that could lead to conflicts. As a result, proactive actions that could effect changes and cause disruptions to existing relationships or status quo are avoided (Kale and Barnes, 1992).

There are prospects of being averse to constant changes within the organisation, whether in management personnel changes or changes in organisational processes and standard procedures without due pre warnings and communication. Such unpredictable actions are viewed as rather risky trends that could predict conflicts and increase anxiety levels (Doney, Cannon and Mullen, 1998). West African's relative high values on uncertainty avoidance exhibit a sense of risk aversiveness and avoidance and would rather engage in guided approaches to conflict resolutions through possible third-party mediation. Members of this

society avoid the consequences of shame and loss of face in their interactions in contrast to the United Kingdom with an assigned relative low score of 25 for uncertainty avoidance, that suggests the societal value orientation of greater individual proactivity, open to taking risks and values creativity and innovation at the workplace (Kannungo and Wright, 1983).

On the culture dimension of masculinity and femininity, Hofstede assigned a score of 46 to West Africa which is lower than the United Kingdom score of 66. The outcome of this orientation is the expectations of increased task challenges and equality of opportunities of both sexes. A study which examined cultural value influences on women entrepreneurship in the West African country of Nigeria, Mordi et al, (2010) found that despite the current democratic government in the country, women are still subjected to the socially constructed subservient roles that impact on their ability to rise beyond such social categorisation. The gender social role construction is prevalent across African society with a high patriarchal system (Kuada, 2009). While Hofstede's cultural dimensions have been adopted severally in conducting organisational research, the theory is not without its criticisms. In the next subsection, the researcher reviews the critiquing of these dimensions as well as basis for their application in the present research.

4.6.6.5 Challenges to Hofstede's dimensions

Hofstede's cultural dimensions have been subjected to criticisms ((Hunt and Levie, 2004; McSweeney, 2002; Peterson, 2003; Kagitcibasi, 1997; Triandis, 1995; Williamson, 2002) despite its popularity (Kogut and Singh, 1988) and the influence of its extensive coverage of global national cultures (Smith et al, 1996) in organisational research and analysis in cross-cultural psychology and international management academic disciplines.

Hofstede's study and dimensions made a great impression with the argument that national culture could determine ways of thinking and reasoning in organisational behaviour and management practices in societies (Minkov and Hofstede, 2001). While Hofstede's iconic ideas and studies on cultural dimensions have been extensively cited and applauded for their clarity and insights (Lustig and Koester, 2013), they have also been subjected to several critiques not only of its logic but also of its methods. In his analysis of Hofstede's model of national cultural differences and their consequences, McSweeney (2002) raised doubts about Hofstede's assumptions, methods, and logic in reaching conclusions about national cultures. He casts

doubts on the validity of the assumption that national cultures could be determined, given possible intervening variables such as organisational and occupational cultures which could influence behaviours and have impact on conclusions. With respect to the methodological approach adopted for Hofstede's study, both McSweeney (2002) and West and Graham (2004) argued that the singular adoption of a population within a single corporate organisation (IBM) may not be valid enough to generalise findings from the study.

According to Triandis (1995), another issue with assuming common national values for individuals from the same nation is the lack of consideration of possible variations in values due to personal and other socio-cultural circumstances. In a study of national identities and value systems, Stelzi and Seligman (2009) argue that, while individuals could learn values over time within the context of family orientations, they could also unlearn and learn other values through other socialisation experiences. Culture evolves and may not be stable enough to justify the argument of consistency of values within societies. However, it has been argued that even as cultures might evolve over time, value differences between societies may not be lost (Inglehart, 2008). According to Kim, Sherman, and Taylor (2009), intra-cultural variations may not be strong enough to nullify research based on culturally based psychological and behavioural patterns. This is because shared group values and experiences over time tend to develop as patterns that would influence how members of such a group think, feel, and act.

Sivakuma and Nakata (2001) believe that, even where cultural heterogeneity is noticed, the dominance of common values that specify common ways of life of the people is fundamentally rooted. Within the context of national cultures as contained in Hofstede's dimensions, culture represents total knowledge within a society, which determines common operative norms and serves as a cognitive tool in understanding behaviour and actions. This resonates in Hofstede (1980:25) definition of culture as "the collective programming of the mind which distinguishes the members of one human group from another...the interactive aggregate of common characteristics that influence human group's response to its environment". In a study which examined arguments for individual and country level value structures, Fischer et al, (2010) argued that societal values are the indirect content of values of individuals in the society and guide societal institutions.

Nevertheless, Trompenaars and Hampden-Turner (2012) argue that it would be an error of judgment to assume that individuals in so-called individualistic societies do not care about communities. A case in point is the United States, which is judged an individualistic society but has one of the highest numbers of community-based organisations. While the above represents a fact, it is recognised that such community organisations were formed by individualistic volunteers who were not under a normative obligation to form these organisations. This is in contrast to normative collectivist societies such as Japan where group membership comes naturally as a norm that defines the individual's responses as a group member. While society members may exhibit individualistic tendencies within collectivist societies, there is usually a push for "sameness" through teachings for the individuals to align their self-fulfilment goals with group aspirations (Han and Chloe, 1994; Kim, 1994). Any feelings of self-distinctiveness that promote overt individualistic behavioural traits of a sense of autonomy are managed through societal inter-connectedness of communal sharing, affection, and social cohesion (Markus and Kitayama, 1991).

According to Hofstede (1994), values of a society or country are not singular aggregations of "average citizens" but rather a set of likely reactions of people who demonstrate and extend the same common mental programming and identities. Cultural value dimensions are based on approximations in collective values, which need not be based only on individual behavioural patterns (Hofstede and Peterson, 2000). According to Trompenaars and Hampden-Turner (2012), cultures exist in relation to how a group or society has organised itself over time within a functionalist paradigm to solve problems and challenges that environments present to them. Values are only valid for relevant categorisations, depending on the research questions (Dawar & Parker, 1994). The adoption of the Hofstede's value in organisational research has been within the functionalist perspective, which allows for the application of uniform values even though there may be variation within values in societies (Fletcher and Fang, 2006; Smircich, 1983). Hofstede's model of cultural dimensions, scholars argue, remains one of the most coherent theories that has resonated with organisational practitioners and managers because of its clarity and parsimony (Kirkman, Lowe, and Gibson, 2006; Smith, 2006).

4.6.6.6 Hofstede's cultural dimensions and the present research

While the researcher acknowledges the arguments in favour of adoption of Hofstede's cultural dimensions in organisational behaviour research (Dorfman and Howell, 1988; Guba and Lincoln, 2002; Shackleton and Ali, 1990), its application in the present research is subjective in understanding the perceptions of West African migrant nurses of their experiences at work. Hoecklin (1996) suggests that the cognitive implication of Hofstede's dimensions is its relevance in understanding people's perceptions of an organisation, as well as interpersonal relationship and roles of its members. According to Stelzi and Seligman (2009), Hofstede's cultural dimensions offer insights in understanding societal functioning and cognitive understanding of events and actions. The researcher also recognises that the Hofstede's dimensions have influenced understanding cross-cultural issues for international management (Schwartz, 1994; Trompenaars, 1993; House, Hanges, Javidan, Dorfman and Gupta, 2004; Lustig and Koester, 2013; Kozan and Ergin, 1999; Tsui, Nifadkar and Ou, 2007). However, the present research equally acknowledges that within West African society, there exist some elements of divergencies within its constituent countries which has been one of the issues raised on validity of application of Hofstede cultural value dimensions in research.

Hofstede's work on cultural values has been influential and variously applied in organisational research such as Chinese and American differences on equity norms (Leung and Bond, 1984), cooperative decision making amongst Chinese and Australians (Chen and Li, 2005), competitive and cooperative behaviours in tasks between Asian, Black, Hispanic and Anglo individuals (Cox et al, 1991), Japanese and European American conflict resolution strategies (Oetzel, 1998), culture and conflict resolution strategies (Kaushal and Kwantes, 2006) and the moderating effects of cultural dimensions on collective primacy (Chen et al, 1998) and power distance values in migrant nurses (Choi et al, 2019).

With the understanding of the issues associated with, and cautious of the Hofstede's cultural dimensions (Brewer and Venaik, 2014) in sampling of current research participants of West African migrant nurses, the present researcher does not assume an objective homogeneity of post-colonial West Africa states. However, the researcher takes a qualitative, subjective approach in considering West Africa as a society of individual countries sharing dominant traditional value similarities (Matondo, 2012). In this way, the Hofstede's values are applied where appropriate as a contextual subjective tool. This is consistent with previous research

(Mordi et al, 2010; Creek, 2015) which adopted of Hofstede cultural dimensions in their examination of socio-cultural practices in countries of West Africa. Kuada (2009) suggests that aspects of Hofstede's cultural values dominate practices in Africa such as in the gender role categorisation consistent with the masculinity and femininity values. While Hofstede added other dimensions such as long-term orientation, the current research limited its investigations to the original four value dimensions namely: individualism and collectivism, power distance, uncertainty avoidance and masculinity-femininity as ascribed to West Africa (Hofstede, 1991).

4.7 West Africa: Indigenous values and beliefs

Fig (4.4) below shows post-colonial West African society currently constituted as nation states.

The researcher, in reviewing the following West Africa indigenous beliefs aimed to further guide appreciation of and insights into the nurses' cultural values.

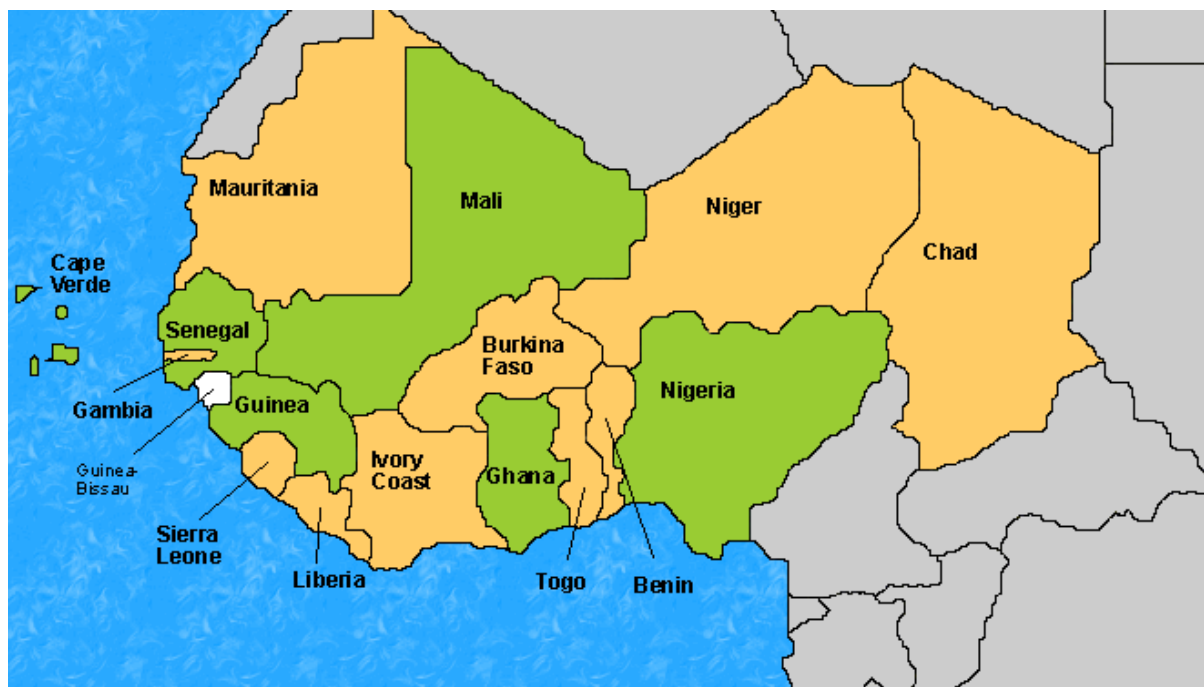


Fig 4.4: Geopolitical map of West Africa shows its present nation states

Sub-Saharan Africa and indeed Africa itself is greatly populated, with over 1.2 billion people in nearly 3, 000 different ethnic groups and over 1, 000 indigenous languages. However, within these complexities, common beliefs and values cut across all countries and transcend languages, national boundaries, and ethnicities to form the common cultural traits of inhabitants of the West African sub-region (Matondo, 2012).

West Africa, also known as Sub-saharan Africa, lies south of the Sahara Desert. The Atlantic Ocean borders its western part and the Chad basin on the eastern border. West Africa has undergone years of social, political, and economic changes but currently composed of seventeen member nation-states (Benin Republic, Burkina Faso, Cameroon, Cape Verde, Chad, Cote D'Ivoire, Equatorial Guinea, The Gambia, Ghana, Guinea, Guinea Bissau, Liberia, Mali, Niger, Nigeria Senegal, Sierra Leone, and Togo). In its current organisation as the Economic Community of West Africa States (ECOWAS), the area occupies an estimated 5, 112, 903km² with a population of about 340, 000, 000m people.

Africa cultural practices have their foundations in oral narratives that anchored on socio-political, religious, arts and craft, music, and language institutions. However, documentations of the earliest explorers were used amid criticisms to triangulate oral accounts of Afrocentric beliefs and values (Nketia, 1982) noted to have transcended generations. In a study based on oral, archival, and field evidence, Hanserd (2015) reported influences of social and cultural expressions among Afro Caribbean nation of Jamaica of West African ancestry. The finding suggests evidence of common norms and values in acts of oath taking, naming patterns and mythic incantations that resonate amongst current inhabitants of the West African sub-region. The implication being that geographical or political demarcations have minimal impact on traditional values of the people.

4.7.1 West African patriarchal social system

The traditional social value of West African communities emphasises a sense of the male gender influence and authority within and outside the families where gender and sexuality are used as personality traits that express human beings. The African socio-cultural outlook on gender is related to a definition of self and sexuality. The socio-cultural definition of the female gender roles is perpetuated through education or rites of the females into what are considered female acceptable norms and behaviours within the society (Moyo, 2004).

There is the social construction of the female gender identity that portrays subordination of the females to the patriarchal authority of the males in the family and are fused within traditional spiritual beliefs that validate the male authority (Babou, 2009; Oduyoye, 2001; Phiri, 1997). The socio-culturally ascribed subordination of females creates a situation that strengthens the institution of marriage of the female to a man as a validating tool for the recognition of the social and economic relevance of the female gender. In a study, Mordi *et al*, (2010) reported findings that gender role categorisation in West Africa continues to impact on their ability to rise beyond such categorisation.

According to Ogunsiji, Wilkes, Jackson, and Peters (2012), in West Africa, migration decisions were predominantly made by a woman's husband because of the cultural norms that subordinates women to men in Africa, in relation to views and opinion. Males are, however, expected to provide for their household and may be considered effeminate if they fail in their duties to provide for their wives and children. This serves to consolidate the men's' sense of responsibility, power, and reverence.

Further considerations of authority and respect in the African society are associated with age and the elderly with a strong assumption that the young learn and adopt knowledge from them (Nyagua, 2008). These practices have also been found to extend beyond family environments, transcending into workplace environments. In a study which examined patriarchalism and workplace behaviour in Nigeria organisations, as social phenomenon, Adisa, Cooke, and Iwowo, (2019) found lack egalitarian social statuses at workplaces with women experiences of subservient positions to males at work.

4.7.2 West African organisational social values

Traditional African organisational dynamics are central to employees' ways of interaction and relationship at work. African leadership style, though consultative to an extent, rests on the patriarchal system that forms the basics of a typical African family organisational setting. Ahiauzu (1986) argues that organisational managerial practices imported into Africa through colonial contraction made most Africans imbibe certain aspects of Western cultures. However, a consequential failure to appreciate the traditional African ways of life, especially in work environments, led to dysfunctional relationships between the "westernised" manager and traditional employees (Abudu, 1986). It is argued that the lack of appreciation of these

traditional values in relation to the centrality of families in work relations affected people's management effectiveness. According to Bassey & Oshita (2010), West Africans share common values in communal co-existence that is usually reinforced through inter-ethnic marriages and associations. This enhances the value of relationships because inter-marital families consider themselves as one and the same family. African cultural values suggest group and communal solidarity with an emphasis on social support and responsibility rather than individualistic existence (Guerin, Diiriye and Yates, 2004; Whittaker, Hardy, Lewis, and Buchan, 2005).

This sense of solidarity resonates in the common idiom among African people. "go the way that many people go; if you go alone, you will have reason to regret." According to Matondo (2012), this common idiom does not suggest sheepish social influence but rather the understanding that existence outside the communal and ancestral co-existence limits one's claim to social identity. One's personal identity is linked to the social identity with one's personal protection and relevance communally determined and guaranteed (Babatunde-Sowole, Jackson, Davidson, and Power, 2016). It is with similar assumptions that the traditional African expression of ubuntu ("I am because we are. I can only be a person through others") remains instrumental and influential in management considerations of people management in organisations (Lassiter, 2000).

While West Africa constitutes different social groups, there is a common widespread acceptance of the cultural values of interdependence, collectivism, sacred rites and religion and respect for the elderly (Hanks, 2008). In a literature survey, Shelton (1964) observed that a typical African who wishes to substitute the traditional communitarian values because of Western education or association risks being ostracised and estranged. Close-knit nature endures through the communities that every member is seen as one and continually related to others by extension through the long-held perception of ancestral root and leanings.

4.7.3 West African traditional values and modern management practices

West African society and organisational practices are articulated to support a collective sense of community (Agulanna, 2010; Mbigi, 2005; Nussbaum, 2009). Organisations and

workplaces are perceived as extensions of their family and social settings as symbiotic units. The family remains the central focus of the average African even at work as the centrality of families with social discourses extend to formal organisations (Aju and Beddewela, 2020). In the context of the African cultural attachment, the work and family interface is in a symbiotic relationship as extensions of relations. The hierarchical family and organisational structure relates to subordinates' respect for status and experience at work (Mangaliso, 2001) which regulates subordinates from challenging ideas or actions of superiors at work. Subordinate often aiming to maintain a non-confrontational relationship with superiors to ensure social and work harmony (Lindsley, 1999; Tyler, Lind and Huo, 2000). This permeates the development of a paternalistic and protective inclination on the part of subordinates who engage in dependency behaviours with a limiting sense of challenging superiors' decisions (Lawrence and Lewis, 1993; Martinez, 2005).

Managers not only provide support to the employees but also take into consideration employees' pastoral needs, which could involve families and other personal issues (Matondo, 2012). There is a thin line between the private life of the individual members of the society and work life and therefore it is not considered intrusive when a manager or leader enquires into the personal and family lives and welfares of the employees (Ubeku, 1983). In such a case, members of African families are happy to discuss family issues with their managers and/or colleagues to support the resolution of family-related issues. The perception of a positive interface between work and family is argued to impact work outcomes, organisational commitment, engagement, job satisfaction and general worker feelings of well-being (Carlson, Hunter, Ferguson, and Whitten, 2014; Haar and Bardoel, 2008). In a study of work-family enrichment that explored levels of satisfaction of Maori employees who are associated with a collectivist cultural orientation, Brougham, Haar and Roche (2015) found a positive relationship between high collectivist-oriented cultures and high-power distance workplace-culture satisfaction.

The family value system reinforces a communal sense of existence within the society and, by extension, organisations. In West African, while employees may not compromise on work ethics, it is also possible to observe that they do not sacrifice family or social values when these are at variance with work issues (Nyasani, 1997). However, there is a collective sense of responsibility at work that defines the collective sense of orientation from families in principle.

4.7.4 West African traditional supernatural beliefs

Peoples of West Africa consolidate their sense of existence through beliefs in terrestrial and extra-terrestrial beings. This sense and belief engage the people in a social sense of collective being and consolidate values common to them. In West Africa, there is a common belief in the continuous performance of roles by their ancestors, whose spirits are still perceived to be efficacious in their relationship with the living beings. Collective beliefs shape the moral compasses of communities and persons (Mbiti, 1969).

This belief extends to the respect accorded to all elderly members of the society, whose seniority is associated with the representation of the ancestral gods (Nyagua and Harris, 2008). Respect for the elderly head of the family and community is associated with age and is sacrosanct (Darley and Blankson, 2008). The young are expected to see the elderly or senior-aged person as a custodian of knowledge from which they can draw inspiration. This sense of community and respect for the elderly becomes an extension of the individual's members' self-identities (Ahiauzu, 1986). Individual members' protection is anchored on the level of societal cohesion and existence because members rely constantly on the support and assistance of others within the community (Matondo, 2012).

The review of the literature above on West African values and traditions revealed ways of life of a people who primarily share common values for communal goals. There are also insights into social construction of roles and the functional sense of patriarchalism. The implication of these for the current research is the relationship of the values with the adopted Hofstede' cultural values used to explore how these values might explain the nurses' perceptions of their experiences at work.

4.8 Collective summary, gaps, and research questions

The literature review chapters shed light on migration themes with outlines of various reasons that individuals move from one place to another. It discussed the possible reason why people, especially professionals from developing countries, leave their countries for developed countries despite high demand and regard for their services in their home countries. The review put into perspective previous research findings on the subjective experiences of migrant nurses in the United Kingdom. In the review, the researcher noted the various research approaches

and methods of data collection used in previous research to examine migrant nurses' experiences in the United Kingdom. Such methods included focus group interviews, surveys, and questionnaires.

The review revealed that previous research focused mainly on the migrant nurses' experiences at work (Shield and Wheatley, 2002; Smith, Allan, Henry, Larsen, and Mackintosh, 2006; Alexis and Vydelingum, 2005). These were in the context of the nurses' experiences of both the organisational processes and interpersonal interactions at work. The reviews also identified previous research (Gerrish and Griffith, 2004; Hardill and Macdonald, 2000) use of mixed sample populations of migrant nurses from different nationalities with possibly differing expectations and experiences (Restubog, Bordia and Bordia, 2009). While this research provided useful baseline information about the experiences of migrant nurses in the UK, there are gaps in our understanding of the deeper circumstances regarding the nurses' expectations and how cultural conceptions might explain their experiences at work in the UK. Allan and Larsen (2003) suggested a deeper examination was needed of migrant nurses' experiences at work, with an emphasis on their ethnic and cultural values to develop more understanding of their vulnerabilities and their perceptions of experiences at work. The present research focuses on West African migrant nurses' expectations, perceptions, and responses in their experiences at work.

Following the review of literature on relevant theories and research, the present research explores the following questions :

(1) What reasons and expectations do West African nurses use to explain their migration to the UK?

(2) How might cultural conceptions explain West African migrant nurses' perceptions of experiences at work in the United Kingdom

(3) How do West African migrant nurses manage conflicts between their expectations and experiences?

Chapter 5: Research methodology and design

5.1 Research epistemological and ontological underpinnings

This chapter explains the epistemological and ontological underpinnings of the research approach and techniques for both Studies One and Two. The chapter also presents the data collection methods, the criteria for recruiting the research participants and the researcher's own reflexivity in the research processes.

A research methodology defines the processes, principles and procedures that are employed in carrying out research and ensures they are consistent with its epistemology and ontology (Bogdan and Taylor, 1975; Creswell, 2003; Guba, 1990). Epistemology represents the source of knowledge while ontology represents the nature of such knowledge in consideration of whether the knowledge is objectively or subjectively constructed (Hussey and Hussey, 1997). This background knowledge informed and justified the researcher's methods of data collection, presentation, and analysis processes (Burrell and Morgan, 1979; Landbridge, 2007).

In exploring, examining, and investigating issues of research to advance knowledge and theory, qualitative, quantitative, or mixed-method approaches can be used. However, the basic distinction among these are assumptions that thoughts and investigations are either based on functionalist objective or interpretive paradigms (Burrell and Morgan, 1979). In the present research, qualitative research is employed to explore the phenomenon of expectations and perceptions of experiences (Creswell, 2003). The researcher relied on the interpretive ontology, which considers knowledge as something that depends on interpretations to evolve meanings (Hatch, 1997; Walsham, 1995).

According to Zyphur and Pierides (2017), with quantitative research, researchers make assumptions about the nature of the construct to be discovered and how it can be represented or replicated for causal inferences. In that sense, the method of data collection is usually based on an intensified structure or parameters pre-set by the researcher. While quantitative researchers use numerical data based on measures (e.g., questionnaires) provided by the researcher, the qualitative researcher assumes a world of phenomena that are subjectively constructed and interpreted (Lewis and Zibarras, 2013; Symon and Cassel, 2012).

Consequently, the method of data collection allows for a low degree form of structure. This gives participants or respondents enough freedom to tell their stories and explain their thoughts and perspectives. The mixed-method research approach lays claims to the possibility of applying both quantitative and qualitative approaches to determine outcomes.

5.2 The choice of the qualitative research approach

In exploring and examining migration reasons, expectations, and perceptions of experiences of West African migrant nurses, the researcher lays no claims to real or objective knowledge. The present research neither tests hypotheses nor does it expect to lay claim to objective realities (Lewis and Zibarras, 2013). The researcher's approach to these inquiries is to engage through reflective structural analysis of the participants' subjective data to evolve insights into their expectations and perceptions of experiences at work (Moustakas, 1994). The researcher, therefore, believes that insights into the nurses' experiences would be appropriately evolved through an intersubjective engagement between the researcher and the nurses' accounts of their perceived and lived experiences.

In carrying out this research, the researcher is of the philosophical view that when perceptions of events, actions and incidents are involved, different meanings can be interpreted within the same situations and circumstances. The research's principal aim is to generate deeper insight into West African migrant nurses as individuals with peculiar perceptions and experiences at work in the United Kingdom (Denzin and Lincoln, 1994; Hussey and Hussey, 1997). This understanding guide both the researcher and the researched in a continuous and interactive engagement process of sense making within sense making (Patton, 2002). In this way, the researcher, through a reflective interpretative approach, extracts, describes and interprets the nurses' subjective accounts of their perceptions of experiences at work within the framework of their cultural conceptions.

In this research, the qualitative research strategy is considered appropriate because the researcher aims to assign meanings through sense making to interpret the nurses' perceptions of experiences as a phenomenon (Brocki and Wearden, 2006; Denzin and Lincoln, 1998). The strategy, therefore, is well suited to provide the rich qualitative data needed to generate deeper insight into the nurses' experiences. The epistemological underpinnings of the research are hinged on the understanding that knowledge is socially constructed. In this case, the researcher

used loose semi-structured interviews to collect the nurses' accounts of their expectations and perceptions of experiences as the main data of the research and the researchers' further reflective engagement of the data to interpretively generate meanings of what the nurses' accounts mean for them. (Eatough and Smith, 2008). The subjective accounts of the nurses' expectations, and perceptions of experience, therefore, produced the rich thick data from which new understandings of the nurses' experiences evolved (Edmondson and McManus, 2007). To strengthen the case for the use of qualitative approach embedding phenomenological techniques, the researcher notes previous empirical works that have adopted these techniques including, "The road to repatriation: implications for HR policy and practice"(Howe-Walsh, 2010), "Choosing your coach: What matters and when; An interpretative phenomenological exploration of the voice of the Coachee" (Jones, 2015), "An exploration of the emotional experiences of Cypriot academics"(Antoniadou, 2013) and "Occupational values of nurses who succeeded their mothers in nursing" (Lee and Kim, 2019).

While previous research on migrant nurses suggests what is going on in relation to their experiences, the current data provide sources for deeper understanding through reflective interpretative processes of what these experiences mean for the nurses. In the process of exploring and advancing knowledge on human actions, behaviours, and perceptions, what is needed is **verstehen**, which involves accessing and examining actual meanings and interpretations that actors subjectively ascribe to a phenomenon and its symbolic relationships (Bratton, Sawchuk, Forshaw, Callinan, and Corbett, 2010). It is, therefore, the researcher's belief that, through an interpretative process, the research's overarching objective of generating further insight into West Africa migrant nurses' expectations and perceptions of experiences at work is attained (Creswell, 2007).

While adopting the qualitative research approach and consequent data collection method, the researcher is aware of its daunting nature. The data collected will vary extensively, which may pose problems in sorting and analysis. There could also be the possibility of respondents deviating from issues that are relevant into issues not relevant to the research (Ashcraft and Alvesson, 2013). The researcher, therefore, put in place systematic cautions in the management of data during both collection and analysis (Gherardi and Turner, 1999). These safeguards are explained under the "researcher's reflexivity and data validation" sub-heading (5.4) of this thesis.

5.3 Research design and data collection

This research is based on a two-study design with data collected in two phases from a purposive sample of fifteen (n-15) West African migrant nurses working in the South East of England. The same nurses took part in both Studies One and Two. In Study One, the template analysis (TA) was used to analyse the data while in Study Two, the interpretative phenomenological analysis (IPA) was used in analysis of data. The manageable sample size of (n-15) participants for both studies was considered appropriate sample size of general interpretative research (Brocki and Wearden, 2006). According to Smith and Osborne (2003), there is no rigidity for the number of participants in IPA research. Similarly, in using TA, samples could vary from as single autobiography to a large study sample (King, 2013). The researcher focused more on the depth rather than the breadth of the data collection by carrying out micro-detailed analysis (Creswell, 1998; Reynolds and Prior, 2003; Saunders, 1982; Smith, 2003; Smith, Flowers, and Larkin, 2009; Watson, McKenna, Cowman and Keady, 2008).

5.3.1 Phases of data collection

The present research incorporated two phases of data collection. In Phase One, interviews were carried out to obtain accounts from participant migrant nurses based on the study aim of exploring their reasons for migrating to the United Kingdom. In Phase Two, further interviews explored the nurses' sensemaking of their experiences at work by encouraging them to provide detailed accounts in own words of their perceptions of processes at work and actions (Ployhart, and Ryan, 2000; Smith, Flowers, and Osborn, 1997; Smith and Osborne, 2003; Watson, McKenna, Cowman, Keady, 2008). of their managers and colleagues which impacted on their feelings and attitudes. Participant nurses were encouraged to think about both good and bad events and actions in order elicit much richer accounts.

5.3.2 Phase one data collection

The first phase in the collection of data formed the core of the data collection process. In the first phase, the researcher collected data for *question on (1) of the research: 1) What reasons and expectations do West African nurses use to explain their migration to the UK?* The researcher aimed to collect data that would help to evolve insights on the reasons and expectations that led the West African migrant nurses to

migrate to the United Kingdom. Study One was carried to provide the background of the nurses' expectations which can help to understand their experiences of the exchange relationships in Study Two. The researcher explained the overall design of the research to the participants and sought their assurances to participate in the second phase of the research data collection

5.3.3 Phase two data collection

The second phase of data collection focused on West African nurses' recollections of actions in relation to their interactions with their native British managers and colleagues at their workplaces. The 'native British managers' and 'colleagues' as used in this research, define the migrant nurses' managers and colleagues at the nursing homes who were born and trained in the United Kingdom. Data collected during this second phase were used to answer the research Questions Two (2) and Three (3): (2) *How might cultural conceptions explain West African migrant nurses' perceptions of experiences at work in the United Kingdom?* and (3) *How do West African migrant nurses manage conflicts between their expectations and experiences at work?* The nurses were carefully guided to think about the actions of their managers and colleagues of British origin in their work interactions, specifically those actions and behaviours that the nurses would consider impacted their feelings and how they coped under the circumstances. The second interviews were carried out one month after the first interview. The researcher made this early follow-up in order not to lose any of the participants. All the participants were still available during this second process. Another advantage of this early follow-up with the second data collection was to ensure that the research aims remained fresh in the participants' minds. However, the researcher re-approached and gave notices to the nurses to reconfirm their availabilities for the second interview. During the reconfirmation of schedules with the nurses, the nurses were apprised of the nature and typical guide interview questions. These were given to the nurses in advance. The aim of sending these guide interview questions was to enable the nurse to think and reflect in advance of the requirements of the questions.

5.3.4 Semi-structured interviews

The main source of data collection for both studies was through face-to-face, semi-structured interviews carried on over a period of one year. The choice of semi-structured interviews was based on its appropriateness with both the qualitative research approach and research

techniques of template analysis (TA) and the interpretative phenomenological analysis (IPA). Both the template analysis and the interpretative phenomenological analysis have been introduced as used in Studies One and Two, respectively. The researcher views the West African migrant nurse participants as individuals whose responses represent the only credible source of data that can be used to explore the objectives and questions of the research (Goulding, 2004; Hussey and Hussey, 1997; Smith, Flowers, and Larkin, 2009).

The loose interview guide for both studies was informed by the research epistemological views (Symon and Cassell, 1999). Interview guides (attached as appendices) were deliberately loosely structured around a few questions to minimise restriction but with occasional probes from the researcher to facilitate participants' elaboration of their points and thoughts on their experiences (Dicicco-Bloom and Crabtree, 2006; Crabtree and Miller, 1999; Smith, Flowers, and Osborn, 1997).

5.3.4.1 Transcription of audio interviews

To confirm the accuracy of the interview data, it was also very necessary to get clearer words and sentences as recorded. The researcher's attempt at using auto-transcriber of the electronic tape recorder did not work because equipment could not recognise some words from a few of the nurses because of their accents. As a result of this difficulties, the researcher carried out manual transcriptions of the audio interviews. To ensure that the transcriptions represent the exact account of the nurses' interview accounts, the textual transcriptions were given back to the individual participants to verify and confirm that they represented their verbatim accounts during the interviews. A few participants made minor changes in the transcripts for clarification before these were applied in analysis. The researcher also sought a peer (fellow research students) review of the themes generated in the analysis to ensure consistency with and rooted in data as transcribed (Goleworthy and Coyle, 2001; Yardley, 2000).

5.3.4.2 Techniques of analysis

In phase one of the research, the researcher examined the reasons and expectations West African nurses use to explain their migration to the United Kingdom. In Phase Two, the researcher explored how cultural conceptions might explain the nurses' perceptions of experiences at work, as well as how they coped in the context of the experiences. In both

phases, the research employed the same methods of semi-structured interviews to obtain data. In the analysis and interpretations of the data, the researcher applied two analysis techniques to examine reasons and explore perceptions respectively (Yin, 1989). The template analysis technique was used in Phase One while the interpretative phenomenological analysis technique, which involves the iterative interpretational process of analysis, was used in Phase Two (Smith, Flower and Larkin, 2009). Both techniques of analysis are consistent with epistemological and ontological foundations that the participants' cognitive inner worlds are understood through the interpretive process and the individual's subjective interpretation (Lewis and Zibarras, 2013).

5.4 The researcher's reflexivity and data validation

Reflexivity enables openness to change and being adaptable in knowledge production and methodological processes (Haynes, 2013). This applied during the researcher's interviews with the respondents. Creswell (2007) recommends, for the validation of qualitative research findings, the clarification of possible biases in the research process. In the present research, the researcher was conscious of his relationships with the participants in the role of a researcher and sharing the same ethnic background. While the researcher's shared identity proved an advantage in gaining access to the participants as well as gaining appreciable levels of trust, this common identity posed its own challenges (Kenny and Briner, 2010; Kamenou, 2007). The shared identity and assumptions were considered a potential problem because the nurses could feel that, as an African, the researcher should already be aware or familiar with the issues being discussed and therefore be less likely to explain or expand on their views and perceptions. Similarly, even though the researcher came to the United Kingdom on a different route and motivation as a student, the nurses could assume him to be a migrant who would share some aspects of migrant experiences.

Based on the above considerations and how these could impinge on the data collection and analysis, the researcher applied an extra sense of sensitivity to guard against preconceptions by maintaining multiple levels of reflexivity at each stage of the processes. The researcher suspended his previous assumptions and prejudices and made minimal interruptions during the interviews. The interview guides were also sent ahead of the interview dates to the participants for familiarisation (Easterby-Smith, Thorpe, and Lowe, 1991). This allowed the nurses' free expressions of their thoughts on the rule of "epoche" (Kvale, 1996). This is to ensure that only

verbatim data of the nurses' perception of experiences at work are used for analysis. The researcher consciously suspended any form of critical judgment that could be associated with previous knowledge and experience (Spinelli, 2002).

On methodological reflexivity, the researcher considered issues of ethics and power relations. According to Rosenthal (1966), a face-to-face interview could present issues relating to class, race, or sexual biases, therefore, it was important to determine how cultural power and class relations could affect the research process (Hayne, 2006). West African society is suggested as a high in power distance with a patriarchal social structure. This could affect the free flow of communication between the researcher, a male, and the nurses, most of whom are females. However, trust was built through negotiation and understanding, hence a sense of openness and respect arose between the nurses and the researcher. The researcher allowed for flexibility in decision making, such as by encouraging the nurses to determine the place and time of the interviews as convenient to them. This was to mitigate any feelings of male gender dominance. A simple but detailed approach used by the researcher to explain the objectives of the research also enhanced the nurses' passionate interest to talk about their experiences (Smith, Flowers, and Larkin, 2009).

During interviews, participants were allowed time to articulate their thoughts and reflect on their actions and reactions to their responses at the time of event or action occurrences (Lee, 1993). To ensure further that the data collected accurately represented the participants' thoughts and perceptions, transcribed texts were returned to the participants for verification and authentication (Hussey and Hussey, 1997; Saunders, Lewis, and Thornhill, 2000; Symon and Cassell, 2013). In this way, the participants had a second opportunity to reconfirm that the contents represent their original views and thoughts valid enough to be used in the processes of coding, analysis, and interpretation of outcomes (Chell, 1999; Lincoln and Guba, 1985).

5.5 Purposive sampling

The researcher adopted the purposive sampling technique to recruit a group of West African migrant nurses (Smith, Flowers, and Larkin, 2009). In choosing the sample, the researcher considers West Africa as a regional society which even though consists of post-colonial distinct countries, share strong and dominant similarities in values and traditions. Purposive sampling is used because of its convenience in working with a small population and when time and

resources are constrained (Saunders, Lewis, and Thornhill, 2000; Watson, McKenna, Cowman and Keady, 2008). To achieve this, predetermined inclusive criteria were set to provide a sample of people with common attributes in line with the research aims and questions (Lewis and Zibarras, 2013; Symon and Cassell, 2012). As a common ground for all participant nurses, each of them identified with common experiences and backgrounds as bona fide West Africans sharing dominant socio-ethnic characteristics as well as previous common post training work experiences in Africa and migration history (Watson, McKenna, Cowman and Keady, 2008). The nurses also share aspects of similarities as in trained and post training work experiences in Africa, similar recruitment, and adaptation programmes to work in the UK and work in independent nursing homes under the management and supervision of native British managers.

5.5.1 Participants inclusion criteria

West African nurses who meet the following conditions were included in the research:

- *nurses born and trained in West Africa and who have had at least two-year post-qualification practice in the home country,*
- *nurses who applied and were recruited through the official international nurse recruitment process into the United Kingdom,*
- *nurses who have undergone the required supervised adaptation program in the United Kingdom and have been granted their nurse's validation pin,*
- *nurses who have migrated to the United Kingdom legally and with the sole purpose of working as registered nurses (voluntary migration),*
- *nurses who have legal migration status covering work and residency in the United Kingdom,*
- *nurses working under the supervision of a United Kingdom-born and -trained manager and colleagues.*

5.5.2 Participants exclusion criteria

The following categories of nurses were excluded even though they may have some ties with West Africa:

- *nurses who were born in the United Kingdom even though to parents of West African ancestry,*
- *nurses who migrated to the United Kingdom either by themselves or with parents and/or spouses through asylum-seeking routes,*
- *nurses who came as students and continued their residency through work permit routes,*
- *nurses who were not able to give face-to-face oral interviews and who were only able to answer questionnaires.*

5.5.3 Recruitment of participants

The recruitment of participants was by self-selection and the snowballing processes.

5.5.3.1 Self-selection

The researcher made initial contact with some nursing homes and sought permission from their management to post information about the research on their notice boards (Hookway, 2008). The recruitment notice (attached as appendix i) provided information on the objectives of the research with a target sample of West African migrant nurses. The notices provided information that the research aims to understand the nurses' reasons for migrating to the United Kingdom; their experiences with their managers and colleagues of British origin and how they cope with issues from their experiences at work. To further create awareness of the research through oral explanations of the aims of the research, the researcher attended Afro-Caribbean migrant nurses' associations meetings and gave out information leaflets to nurses. Many African nurses contacted the researcher through emails and telephones indicating their interest in participating in the research.

This clarification was provided in the notice to avoid recruiting a biased sample population. (A copy of the invitation notice is attached as an appendix). According to Symon and Cassell

(2012:43), “*participants who self-select by responding will often do so because they have strong feelings or opinions about the research ...*” This was evident with the participants in this research whose interest explained their willingness to encourage others to take part, hence the second recruitment process of snowballing.

5.5.3.2 Snowballing

The snowballing technique is based on peer reference, where research participants contact other prospective participants who met the inclusion criteria (Richard and Morse, 2007). The researcher in the present research made initial contacts with potential nurse participants through visits to nursing homes within the South East of England. However, some of the nurses who met with the researcher were migrant nurses from other countries and therefore fall outside the criteria. Since it was not possible for the researcher to meet other nurses of West African origin within the nursing homes visited, further appeals were made to the nurses to help make contacts with their peers (Saunders, Lewis, and Thornhill, 2000). Some of the nurses, through their associations, assisted in contacting other nurses during their meetings and the researcher followed up on those contacts.

5.6 Participants invitation and consent

The researcher sent formal letters of introduction and invitation to identified nurses (sample of the letter is attached as an appendix ii) following confirmations of intentions through emails and telephone calls. In the letters sent out to the nurses, the researcher further explained the aims of the research and what the nurses’ involvement in the research would mean. For instance, the expectation for the nurses to take part in both studies one and two of the research, that the data would be collected through interviews and the approximate time duration of the interviews. The researcher used telephone calls to follow up on prospective nurse participants to confirm receipt of the invitation letters and consent notes.

The nurses had time to review their interests and understanding of what would be required of them to establish informed consent (Beauchamp and Childress, 1994; Holt and Walker, 2009; Hussey and Hussey, 1997; Saunders, Lewis, and Thornhill, 2000). Some nurses were willing to participate in a research questionnaire but could not take part oral face to face interviews.

The researcher explained the research's preferred method of data collection of semi-structured interviews to the nurses. The researcher thanked this category of nurses for their interest but politely explained that no questionnaire would be used, hence only data from nurses who agreed to be interviewed were used on both phases of the research.

5.7 Ethical considerations

Ethics are codes that guide academic research (Wells, 1994). Birkbeck, University of London, the home of the present research, guides and ensures that all research conducted within the university involving human participants follow set ethical processes. Other reasons to follow the university's ethical guidelines included the researcher's appreciation and care that the human participants in the research are not exposed to any form of harm (Diener and Crandall, 1978) and that the research is conducted with the voluntary participation of the nurses. Prior to collecting data, the researcher completed the university's research ethics form (a copy is attached as an appendix vi).

To conform to the ethical guidelines, the researcher developed consent forms (attached as an appendix iii) that were given to the participants to read and sign to indicate their voluntary participation in the research (Saunders, Lewis, and Thornhill, 2000). The researcher explained to the participants that they are under no obligation to sign the forms but that signing forms confirmed their voluntary acceptance to participate in the research.

The nurses also understood that they were free to withdraw from the research at any point and request that any of their data collected be removed (Cooper and Schindler, 1998). Additionally, the researcher ensured that there were no young and vulnerable persons involved in the research. (A copy of the university's ethical approval form is attached as an appendix v.) The participants were also reassured that the data collected from them was only to be used for the purposes of the academic research and that no personal or organisational identification details would be requested or retained after the interview and analysis (Bryan and Bell, 2011).

5.8 Anonymity of participants

To safeguard their and their organisations' anonymity and privacy, the researcher assured the participating nurses that none of their personal details or their organisations would be identifiable (Bryan and Bell, 2011). These would also not be made available to a third party and would not be included in the research (Easterby-Smith, Thorpe, and Lowe, 1991). The researcher ensured that no identifiable details of the participants are included in any part of the thesis. Pseudonyms were used to identify the nurses rather than real names.

Interviews were recorded using a digital electronic recorder and later transcribed and saved in the researcher's password-protected personal computer accessible only to the researcher. The versions in the electronic recording device were deleted after transcription. These measures were reassuring to safeguard the nurses' confidentiality and privacy. To further make them feel at ease with the processes, the nurses chose their preferred locations for the conduct of the interviews. Most of them made choices to have their interviews conducted at their homes or the researcher's when they are not on duty at work.

Table 5.1 The demographics of West African nurses who participated in the research

Table (5.1) below shows the fifteen (15) West African migrant nurses who participated in the research for both Studies One and Two. The sample consists of 3 male nurses (20%) and 12 female nurses (80%). The average age is 46 years, ranging from 38 to 52 years. The average post-qualification work experience prior to migration (PQWEPM) is approximately 5 years. A total of 5 (33%) nurses are on the migration status of indefinite leave to remain (ILR) in the UK with the remaining 10 (67%) nurses on the migration status of work visas (WV). While the present research specifically focused on West African nurses and their experiences at work with native British managers and colleagues, the nursing homes where the nurses work have other staff members from other minority groups such as East Europeans, Black and Asian British, Filipinos etc.

WafMNs	AGE	SEX	MARITAL STATUS	PQWEPM	UK IMMIGRATION STATUS
Joke	50	F	Married	8	ILR
Adama	42	F	Married	5	WV
Azeez	45	M	Married	3	WV
Bash	42	M	Married	4	WV
Tunde	46	M	Married	5	WV
Bose	38	F	Married	3	WV
Tina	48	F	Married	6	WV
Jenny	52	F	Married	8	ILR
Ronke	43	F	Married	4	WV
Joyce	52	F	Married	7	PR
Mary	47	F	Widowed	5	WV
Mam	49	F	Married	6	WV
Irene	44	F	Married	4	ILR
Amie	48	F	Married	5	ILR
Peace	52	F	Married	8	WV

Chapter 6: Study One

Study One was conducted to explore research Question One: *What reasons and expectations do West African nurses use to explain their reasons for migrating to the UK?* In this chapter, the researcher outlines the process of how data was collected and analysed to produce thematic results and findings.

6.1 Data collection

In the first phase of Study One, the nurses were interviewed at mutually agreed locations. Most of the nurses accepted being interviewed at their homes when they were off work. This option was convenient also because the nurses avoided being interviewed at work for fear of reprisals. This option also increased the attention and concentration of the nurses during the interviews.

Each of the interviews lasted approximately 50 minutes to an hour. Interviews were audio-recorded with the prior permission of the nurse participants. The researcher wanted to allow participants to tell their stories of their motivations and expectations. To ensure focus and avoid superficial and shallow responses, the researcher used a loose interview guide (Potter and Wetherell, 1987) to guide the nurses' reflective thoughts on their motivation and expectations (Lindlof and Taylor, 2002). The researcher also used occasional probing questions to get the nurses to clarify issues in their responses (Polit and Beck, 2012). In this way, deeper viewpoints and insights were generated. In seeking an understanding of the nurse's choice of careers, the following question was asked: *"Tell me about your choice of nursing as a career."* Scholars believe that in collectivist societies, parents and families choose careers for the children (Leong, Hardin and Osipow, 2001). In using this question, the researcher further aimed at exploring the influence of families and the nurses own career ambitions and desires which could inform insights into their occupational successes, job satisfaction and tendency to remain at work. (The interview guide used in study one is attached as appendix iv)

On the nurses' decision to migrate to the United Kingdom, the following questions were posed: *Tell me about your work experience in your home country before you migrated to the United Kingdom; What issues did you consider especially important to you in your decision to migrate to the United Kingdom? Tell me about the challenges (if any) that you faced in decision to*

migrate to the United Kingdom, please. The researcher also explored how the reasons for their migration formed their expectations of in the United Kingdom ;: *In your thoughts, how would you summarize your thoughts about your expectations in your decision to migrate to the United Kingdom to work as a nurse.* The questions were guided by the understanding that all the nurses who participated in this research were in full-time employment in their home countries before migration. The inclusion criteria also meant that only nurses with post-qualification experiences in their home countries participated in the research.

6.2 Data analysis

The template analysis technique was used in Study One because it suited the study's epistemological position (Duberley, Johnson and Cassell, 2012). In this study, the researcher aimed to identify themes in the migrant nurses' data that were relevant to their reasons and decisions to migrate to the United Kingdom. The template analysis has been applied in understanding organisational research issues such as "UK managers' conception of employee training and development" (McDowall and Saunders, 2010) and "exploring ethnicity in organisations" (Kenny and Briner, 2010).

The researcher, even though he is aware of possible generic reasons for migration as contained in the reviewed literature, believes that the reasons and expectations for West African nurses' migration can only be evolved through the migrant nurses' own data from their interview accounts. This is because of peculiarities in individual circumstances to time, resources, and environment. The researcher therefore anticipated possible new themes on the nurses' reasons and expectations on their migration to the United Kingdom. To achieve this, the researcher maintained an open neutral mind to avoid biases in the themes (Brooks, McCluskey, Turley, and King, 2015). The researcher, in setting the initial template avoided *a priori* reasoning drawn from existing theories in advance. Instead, the researcher depended on generating, reviewing, and defining initial codes from the nurses' data accounts (Slade, Haywood, and King, 2009).

As shown in Fig (6.1) below which shows the process used in analysis of the data. The researcher transcribed participants' interview transcripts, read through and familiarised himself with the contents. The researcher identified the initial codes relevant to the research questions on the nurses' explanations of their reasons for migration to the UK from the first two participants' transcripts. However, the researcher was not dismissive of what literature and theory suggest of possible reasons for migration even though no specific study has been carried out on reasons for West migrant nurses' migration to the United Kingdom. The researcher also kept an open mind on any new issues as codes which could be identified from other nurses' transcripts.

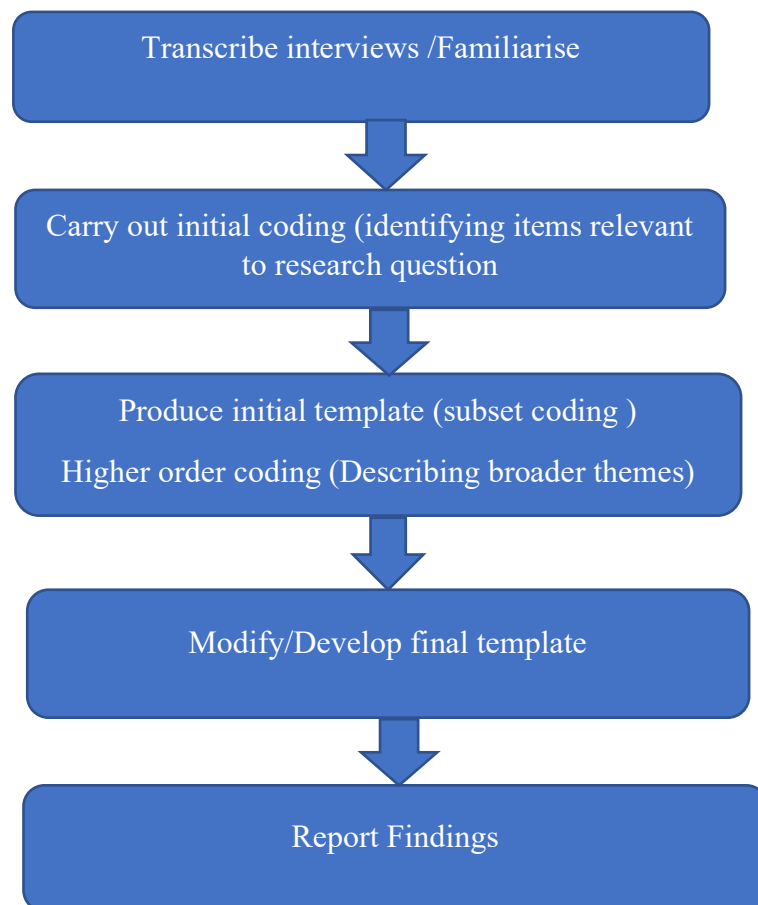


Fig (6.1) The template analysis process (study one) (<https://research.hud.ac.uk/research-subjects/human-health/template-analysis/what-is-template-analysis/>).

The processes, involved the researcher reading and familiarising himself with the data, identifying key issues that relate to the research questions, examining identified issues and concepts as codes across all the nurses' accounts and identifying and defining themes that capture relevant issues. In doing that, the researcher adopted the following guidelines for starting with higher-order codes and narrowing to specifics. In this way, the research reduced the data into smaller analytic bits through identification of potentially significant codes (Huberman and Miles, 1998; King, 2004; King, 2013; Langdridge, 2004). The researcher, in generating and developing the initial template, read through the interview transcripts of the first two nurses to highlight concepts that appear in the data which were considered relevant for the research questions. In doing this, the researcher considered the participants strength and varieties of feelings and how many of them felt and mentioned such concepts. For instance, on reasons for the nurses' decisions to migrate, the researcher paid attention to words, phrases or statements that indicated needs and strong drives that appeared regularly in the nurses' responses (Strauss, 1998).

Table (6.1) below shows the initial potentially significant concepts identified and extracted by the researcher as the initial codes. On the nurses' explanations of their reasons for migration and formation of expectations, the researcher sifted terms in the nurses' data that related to the nurses' careers and work. The initial concepts identified included skills, training, fair treatment, learning, values of training. Further, the researcher noted other concepts based on the nurses' responses on social and status considerations, possible economic and material considerations, and other personal circumstances.

Table 6.1 Study One initial codes from the nurses' data

Concepts identified from data	Initial thematic groupings
Passion, care, environment, value of service, performance and reward, respect, fair treatment, career hopes, stability and job tenure, opportunities, skills and knowledge, learning options, knowledge gaps, better equipment, retirement, old age, political office, upgrade, career change, general nursing	Career and Work
Roles, expectations, resources, responsibilities, standards, values, communities, currency values, income differences, investment options, value for money, big party, celebrations support	Financial and materials
UK values, people's perceptions, quality, value for marriages, network connections, communication, cultural distance, statuses, reverence and relevance, family precedents	Social values

6.3 Modification of template

The researcher modified the initial template to determine the final template, as shown in Table 6.2 below.

<p>1 Reasons to migrate anchored on expectations</p> <p>1.1. Upskill and improving knowledge</p> <p>1.1.1 Advanced clinical facilities</p> <p>1.1.2 Continuous training opportunities</p> <p>1.1.3 Quality and values of training</p> <p>1.1.4 Empowered to contribute to health services</p> <p>1.1.5 Career goals</p> <p>1.2 Safe working environment needs</p> <p>1.2.1 Respect at work</p> <p>1.2.2 promotion on merit</p> <p>1.2.3 health and safety matters</p> <p>1.3 Sustaining family economies and financial needs</p> <p>1.3.1 Breadwinner goal</p> <p>1.3.2 Return on investment</p> <p>1.3.3 Quality living standards</p> <p>1.4 Personal and family social prestige</p> <p>1.4.1 Personal self-esteem</p> <p>1.4.2 High social considerations</p> <p>1.4.3 Family respect and regard</p>

Table 6.2: Study One final template showing themes from categories of coding from the nurses' data

In determining the final template, the researcher sifted through all nurses' responses and organised similar words and phrases to identify categories for the themes in relation to the study questions. For instance, where participants used sentences to emphasise the meaning of their reasons for and expectations on migration, these were connected and, where appropriate, were used to remodify the template, as necessary. The researcher used different coloured highlighters to identify and indicate the textual reference of significant concepts linked to a category as contained in the template. For instance, where a participant has mentioned concepts of monetary or material utility, this was connected to the economics theme. While doing this, the researcher was conscious to avoid being tied to the initial template categories but looked out for any divergences across all participant nurses' responses. In the process, the researcher identified differences and similarities in other nurses' accounts and connected these into the template as applicable. In this way, a structured account of relevant themes was generated across all migrant nurses' interview data.

To avoid the impact of possible deviation from the main data that could easily affect findings, the researcher constantly referred to the transcripts. In this way, the template was modified until it was certain that no new issues could emerge. While reading and re-reading the nurses data for template modification, the researcher included new relevant categories and adjusted any categories that did not serve the purpose of the research questions and aims (King, 2013; Langdrige, 2004). Where some of the nurses mentioned respect and positive societal values placed on sojourners abroad, these were categorised into the initial decision points of "social value considerations." For the initial template, the researcher also identified significant concepts relating to monetary needs and family material responsibilities. In this way, similarities and differences were replicated through matching based on frequencies of responses across each of the other migrant nurses' interviews. During template modification, the researcher formed the thematic connectivity of these categories through regroupings or clustering.

The researcher looked for patterned meanings within the data set and eliminated nodes in the initial template that did not have a general mention across the participants' responses. Further closer readings of transcripts led to the identification of relevant common ideas related to

original codes and concepts. For instance, such concepts as training, better education, good education, good environment, UK education, better preferences, and good equipment were considered. The responses from the nurses on these concepts were found to be significant because many of the nurses mentioned statements or phrases that indicated a theme. This rule was adopted to identify the most common reasons and experiences of the nurses. The researcher followed the interactive process continuously between the categories and the data of all participants until it was determined that no new issues could emerge from the data. This was determined because no further new categories were identified. The final themes that emerged because of the researcher's inductive interrogation of the categories drew illustrations from each of the nurses' transcripts as linked with direct quotes (King, 1998)

The decision to migrate for most of the nurses was determined to an extent by the support and approval of their family members, including husbands. Further issues revealed from the data were some of the nurses' considerations of the logistic conveniences such as an easy medium of communication, the English language, which is seen as a universal language. Even though responses listing this among reasons of migrating to the United Kingdom were in the minority, the researcher took note of these responses. The nurses who mentioned this reason claimed that their primary language of communication in their home countries was French. However, they found the English language quite easy to adapt to, even in their home countries.

Participants' responses also revealed and suggested the importance of information from their peers and friends who are living in the United Kingdom. They painted particularly good pictures of life abroad with tips on the high economic benefits of working in the United Kingdom. Participants used this information to compare with their current employment and working conditions at home. From the participants' responses, an issue of common importance to them was the initial support given by family members. The researcher took these accounts into consideration.

6.4 Findings

The findings of Study One suggest that West African migrant nurses made conscious decisions to migrate to work in the United Kingdom and therefore fitted appropriately as voluntary migrants. The participants answered questions on their motivations and expectations in their decisions to migrate to the United Kingdom. Following analysis of the nurses' interview transcripts, the researcher generated, reviewed, and defined four themes which suggested explanations for the reasons and expectations of West African migrant nurses to the United Kingdom

These reasons were presented under four themes identified as dominant in the nurses' responses including aspirations to improve on skills and knowledge, aspiration for a safe working environment, aspirations to meet and sustain families' economic and financial responsibilities, aspirations to enhance personal and family social statuses.

6.4.1 Theme One: Upskilling and improving on knowledge and skills

The data suggest that, in choosing to migrate to the United Kingdom, many of the nurses reviewed their options on the basis of precedents and information available to them. With perceived opportunities for continuous learning while working, the nurses found the United Kingdom a choice migration destination. Many of the nurses' claims of rejections of several other job offers from other countries that were considered opportunities to make money suggest that other motivations could have informed the nurses' decisions to migrate to the United Kingdom. In comparative terms, the data suggest that the nurses' considerations of the work environment and opportunities to advance careers were much more evident in the United Kingdom than any other country.

In the following interview quotes, Jenny, Mam and Peace highlighted the attractions of further training and working in the United Kingdom as a great opportunity to improve on knowledge in nursing and nursing practice:

'I have reached the post of matron ... (paused), I mean, I was already a hospital matron (a higher position) before I decided to come over to England to improve myself ... I was offered jobs in the UAE but hmmm, no ... I refused it. It was a good offer, but everything is not about money... you have to think about other things. I wanted to improve on my skills. You cannot

compare UK with that ... The UK has the environment and skills you can gain from ... they have the equipment ... But even if I go to any country ... no matter how long I stay in a different country, I will still end up in my home country ... but I must prepare myself for the future” (Jenny).

“Why do you think that our leaders come here for their treatment, the hospital equipment here makes you enjoy working as a nurse...? Shoo, that’s it, oooh. But unfortunately, I am not even using the equipment much because of my job environment ...I am in a nursing home now where we only see hoisters and poos” (laughs). You know, the Arab countries have a lot of opportunities for nurses’, but money is not everything, I can as well stay in my country What about your dignity at work? Hmmm, I can’t go to any Arab country oo... but my plan is to work where I can gain more exposure on other areas of nursing and medicine then when I go home, I have better opportunities. There is no place like home” (Mam)

“My country is small. We have a lot of opportunities in government, If I develop in my career, maybe have higher qualification, I can be appointed a government official. Even my friends who I finished school of nursing are getting appointments now. But it is very easy if you another qualification from overseas, especially UK. You see what I mean. In fact, my husband encourages me every time to make sure I have another qualification from the UK” (Peace)

The high value placed on qualifications earned in the United Kingdom induced expectations of acquiring quality skills and knowledge by the nurses in their decisions to migrate to the United Kingdom. Such considerations were based on perceptions that the United Kingdom's qualifications and training would enhance one's chances of being respected and recognised in their home countries. The United Kingdom was considered a model for excellence in academic training and gaining professional knowledge and so became quite attractive for the migrant nurses. Many of the nurses were also considering careers outside nursing in their home countries. It, therefore, suggests that the nurses' further plans of engaging in future roles in their respective countries would have informed their decisions to migrate to the United Kingdom to earn more qualifications.

The nurses, according to data were not only concerned with the current situation in their counties regarding the lack of opportunities to enhance their skills and knowledge, but they were also conscious and apprehensive of their future professionally.

Tina and Amie, in the following interview quotes, demonstrate the desires of many of the nurses to come to the United Kingdom for the effects of the nursing experience on their future plans.

“It costs a lot to come to the UK as a nurse...But when you think of the benefit, every nurse wants to come but not every family have the type of money that you use to come here. So, you thank your God if your family can bring you here. It changes your life if you can have better experience in the UK or any other developed country and you go back to your country with respect ... you are valued if you are from the UK. Every hospital would like to hire you” (Tina).

“In my country, even in government appointments, if you have UK training and work experience in your CV, they see you as very qualified. We have a lot of opportunities in my country even after your career. My country is a small country but if you have education and good work experience, you can be anything in government. So, when you study in the UK or you work in the UK, to God you are in good position” (Amie).

The data further suggest that, even within families, there were siblings as well as inter-family ego drivers on where each family member studied or earned qualifications. There were, therefore, constant intrapersonal and family competitive tendencies with the aim of achieving personal and family intrinsic satisfaction. These were indicated by the nurses’ constant references to “what it means to obtain” qualification and training in the United Kingdom which suggest strongly of intrinsic joy and satisfaction motives. The theme of skills and knowledge development to enhance their careers was identified following recurring references in the data the United Kingdom being considered a model country for clinical training and education.

Participants in their responses explained their hopes of achieving and realising career goals through a privileged opportunity of working and learning in the United Kingdom. The United Kingdom was perceived as a nurse-friendly environment that offers great learning experiences that are respected across the world, including in the nurses’ home countries. The nurses compared these expected chances with conditions in their home country’s working and training environment, which, in their assessment, is a large gap. While the nurses considered and made references to worsening economic situations in their home countries and the attraction of the pound as a strong currency, there was noticeable understanding across many of the nurses’ accounts that they come from above-average families in their home countries. Joyce and Tunde,

Bose and Mary in the following extracts, demonstrated those intrinsic feelings of personal and family egos.

“We are not poor by any standard in my country. My husband is a medical doctor practicing back in my country, I made the move to catch up on my career. In my family even from before I got married, there is competition amongst us to always improve ourselves. So, my coming to England is to fulfil some of the desires to be proud of where I have trained” (Joyce).

“...most of our present leaders and successful professionals studied abroad. We have a system that sometimes does not encourage quality training and practice, so the best option is to go abroad ... our politicians and rich people send their children to America and UK to study Ah, it's because of the quality, oooh. I want to improve myself. If you travel abroad or train abroad, you are respected. If I go back, I will be a big fish in small pond, you know” (laughs) (Tunde).

“When you go to any place, the first thing is to improve on your knowledge because knowledge is power. If I have a degree in nursing or midwifery, I can easily become a lecturer if I don't want to work in hospital anymore. I planned to go back after some time in the UK. I am not young so wanted to go and contribute to my home country” (Bose).

“In Africa, we do general nursing, but here ,you have opportunities to specialise in some kind of nursing or even another medical knowledge that you want...I am even thinking of doing training on physiotherapy but no time sometimes for me now”(Mary)

Many of the nurses' responses suggest the nurses' recognition of the high social values accorded to families in home countries whose members are either working or studying abroad such as in the United Kingdom. Therefore, moving to the United Kingdom to work and acquire further skills and knowledge were of social value significance for the nurses, hence served as an aspirational factor in their migration to the UK. Across the nurses' accounts was the assumption that in their home countries, even families with above-average economic means are rated behind those whose members study and work abroad, especially the United Kingdom or the US.

6.4.2: Theme Two: Safe working environment

Many of the nurses had strong hopes and expectations of achieving personal well-being and a conducive and employee-friendly work environment, hence the attraction of the UK. Given previous experiences in their home countries with incidents at the workplace that were considered unfriendly made it less satisfying to continue to stay in such employments, the United Kingdom as a destination country seemed to be a safe working environment. There were expectations for improved practice opportunities, a better quality of life and personal safety at work, which to them define well-being. Peace, in the following extract, highlighted issues relating to reasons and expectations for migrating when compared to the home country situations.

“You cannot compare what we have in Africa about healthcare to what is here ... sometimes you don’t even have electricity, working equipment are old or you are talking of corruption, favouritism that make these things not to work” (Peace).

It is evident from the nurses’ responses that their considerations of their previous work environment played a great part in their decision to leave previous jobs and their countries to migrate to the United Kingdom. Their perceptions of the previous work environment as expressed in their relationship with their managers and the inability to utilise their skills due to lack of necessary tools and safe processes are also indicated in their responses. Mam drew inspiration from information supplied by friends in the United Kingdom and decided against the option of making extra money in other destinations, as did Irene in the following extracts on concerns about the work environment and well-being at work.

“Even though I know by myself that it is not going to be easy, but since I have made up my mind, I know I will achieve what I want. I know there will be no going back because no matter what will face me abroad, I felt it cannot be worse than what I already feel at my place of work then back home. I was looking forward to a strong of better place to work. My friend told me that everyone is respected at work because England is a civilised country, some of my friends are in Qatar, some in Dubai but I don’t want to go there. They say the pay is much better, but

you cannot compare that environment with the United Kingdom...but I don't know whether I am right now" (Mam).

"One of my friends left the US and went to Kuwait to work as a nurse because of the money that they promised her, but, my dear, if I tell you her story in that country, you won't believe it. Sometimes I think that what you don't know, you may think someplace is haven. But I was happy coming to the United Kingdom. The people are at least civilised ... some people in some countries are worse than animals, my dear. You cannot enjoy your freedom, you cannot say your mind even as a woman, you cannot contribute even with your knowledge, So, let them be with their money, but nothing than peace of mind and respect where you work" (Irene).

In their home countries, the West African nurses' feelings of anxiety within an unregulated work environment where unethical practices take place increased the nurses' desire to find alternative environments of employment that could guarantee their work safety. The data suggest that the nurses considered the perceived civilised work environment in the United Kingdom as a positive pull and reason to migrate.

"In my country, everyone nurse wants to get job at better hospitals ... so everybody wants to work with the private hospitals. At home, we struggle to get the necessary support, if it is not favouritism, sometimes it will be sexual harassment. No one cares what happens to you. It is either you leave the job, or you follow them. There is no policy to protect you. Even if there are laws, they will ask you, are you the only one. So it is not how knowledgeable you are but who you know and how you can allow yourself to be used? (Tina).

In terms of a conducive work environment, nurses' responses suggested difficulties in obtaining working tools, which demoralised them. They explained the difficulties they faced in working within environments associated with double standards. In situations where rewards do not come due to possession of skill, knowledge, or contributions but based on warped organisational values that no one challenges. This would explain the nurses' loss of senses of job satisfaction which impacted commitment and high intentions to leave their organisation. These reasons informed why some of the nurses who have reached top senior management positions feel that the dominant reasons that consequently informed their expectations were considerations of the work environment.

“When you train to practice in your country and there is nothing to work with, you will feel frustrated. Even those that work in government hospitals like the doctors run their own private clinics. They sometimes get their medications from the government hospitals. All of them have private hospitals. They will then be referring patients to them. There are a lot going on. Who are you to challenge them? They will tell you it is the system” (Ronke).

Many of the participants in this study expressed high ethical resentments about work practices in their home countries. These sentiments further explain the role of moral and spiritual values attach to the perceptions and identities. Bose and Jenny in the following quotes raised personal concerns which related to happenings at their previous place of work at home.

“My dear, I was born in a strong Christian family and we cherish our Christian values. When things are bad, they are bad. In working in a third-world country and you believe in good practice, things are there that will not allow you to do your job the way your conscience directs you. So, what do you do under the condition? It happened to me. I cannot stand it for long” (Bose).

“My decision to come to England because I don’t want wahala (hassles) in my life. I resigned from my senior position back home, not because I want to train again as a nurse. I was a big woman as far as nursing is concerned. But it all about personal choices. When things happening around you make you feel uncomfortable ,you leave. I respect myself and don’t enjoy competition with the younger generation of nurses at work” (Jenny).

6.4.3: Theme Three: Sustaining family economies and financial needs

The data from the nurses’ interviews revealed the impact of the nurses’ socio-cultural backgrounds on their considerations of economics as one of the reasons for migration to the United Kingdom. While some of the nurses claimed low motivation from the economic and financial considerations, they also underscored the high expectations that their socio-cultural backgrounds impinge on them. Nurses, as with other trained professionals from Africa, are regarded as breadwinners in their families. This burden is even more increased with their migration to European countries or the United Kingdom.

In further considerations of the economic reasons for their migrations, the nurses conceded that there are extensive gaps between the United Kingdom and the West African countries. The

exchange rate differences between the pound sterling and developing home currencies present the current motivation for their current continued desire to stay in their jobs in the United Kingdom. It is evident that being one of the world's strongest currencies, the British pound attracts a lot of economic migrants, especially from weak economic and currency zones.

"... The UK currency is very strong when you compare it with the currency in my home country. Many people that live abroad like in UK are building very good houses in my country. For instance, now, since I came here, I know how much I have sent home ... But this makes me happy even though I am under pressure working here" (Bose).

Many of the participants illustrated with accounts that indicated the massive unequal economic strength of the home countries' gross domestic product (GDP) compared with the United Kingdom. The nurses' considerations of economic reasons became more appealing to the nurses rather later in their stay in the United Kingdom. As most of the nurses began to feel they were losing out in terms realising academic and high training dreams, the option of earning more money became more prominent. However, while the nurses feel their current, greater efforts to make more money have an impact on their wellbeing ,emotional and physical, they feel satisfied to an extent with their material and financial contributions in home countries through their earnings. In the following interview quotes, Amie reiterates the general positive atmosphere in families of prospective migrant on their expectations and feelings.

" I cannot lie to you, you know that yourself (referring to the researcher), preparing to go the UK is like a big celebration in our families. Everyone will be there that night, like a party because everybody knows what it means to get a UK visa to come and work or study here. For me it was a big party the day I was leaving...tears were tears of joy even though they will miss you physically"(Amie)

The exchange rate, cost of living and the huge financial responsibilities, even though they were less of a push initially, became a strong incentive to stay on in the United Kingdom. Therefore, it was not just the lure of the strong economy and currency of the United Kingdom, but a strong sense of personal fulfilment through potential earnings that increases their capacity to meet the expectations of families back home. The multiplier effects of the strong British pound sterling became one of the overriding reasons to continue to stay in the United Kingdom. The consequence of this reason was found to be that, with multiple financial outlets for the nurses,

there were feelings of satisfaction when they could meet their immediate and extended families' expectations.

“(....) When you change the pounds into my country's currency, you have good money. You use the money for good projects, pay school fees even those in universities. I have set up some people in small retail businesses so that they will not be relying on me every time. Just buy them out of the trouble they give every month ... Auntie, send me money for this and that,my dear. It's not easy and they don't understand what I go through in this country. With a lot of insults and heartbreaks every day at work where no one appreciates what you do” (Mary).

However, the data suggest that, related to the economic enhancement, the nurses had positive feelings about their guaranteed earnings and planning. These formed expectations for the nurses that, through their earnings, planning could be guaranteed as their wages were guaranteed. There were references to what previously obtained in home countries where wages are not guaranteed with incessant industrial actions and professionals boycotting services due to unfulfilled conditions of service. Furthermore, the nurses' collective responses revealed the consideration of their real wages, cost of living and living standards in their home countries.

“(.....) At least, I will know that my salary is guaranteed. In my place, sometimes, workers including nurses and doctors are owed salaries. That is why you see so many strikes every time. When you are not sure of when you will receive your salary at the end of the month, how do you plan or provide for your family, you see that's one of the reasons I decided to move when I had the opportunity ... I am getting the money, but I cannot say it gives me the happiness I wanted. My family back home need me as I need them. I am sending money home but that is not all” (Adama).

“Even though, in my family, we are above average, my earnings and savings from my job in my country was not enough to pay for my coming to the United Kingdom ... It was an expensive venture, my dear, you know that yourself. Even when we have decided for me to try the movement (migration), the wahala (problem) was how do we get the money for me to process my application and even to pay for my flight to England?” (Azeez)

The participants expressed a strong motivation to earn money with expectations of building the family economies back home. The participants responses revealed a communal sense of sharing

family responsibilities. Although previous assumptions in African societies were that women are basically homemakers who depend on their husbands to provide for the whole family, the participants' responses suggest otherwise.

Most of the participants were women who confirmed their expected responsibilities in relation to their nuclear and extended family upkeep. However, the nurses' responses also highlighted the traditional perceived roles and positions of women within West African socio-cultural settings and the gradual shifts and contradictions with such assumptions. In their traditional setting, women were expected to play the role of housekeepers and housewives.

In their responses, a majority mentioned that the patriarchal traditional nature of the African society that places the African woman as the homemaker changes when a woman has a career such as nursing. However, with women getting into education and forging careers, their roles in both their nuclear and extended families enlarge, such as in sharing in household material and financial responsibilities.

While the participants claim that most women in Africa are basically expected to get married, bear children and care for both their children and the husband at home, findings from present study suggest that, even as married women, the nurses have many financial obligations. The financial expectations on the nurses sometimes cause matrimonial problems because of control issues between members of her maiden home and their husbands. Each side of the family feels that the nurse should be more obligated to their side of the family. It is, therefore, a huge obligation on the nurses that they need to have enough material resources to cater for both families.

“In my place, even if you are married, you also take care of your maiden family if have the means to do that. As a nurse, everyone in your family looks up to you for money. Nursing is like a degree in my place, so I am the breadwinner in my family. So, I said to myself, it will be better if I travel overseas” (Amie).

Findings from the nurses' accounts further suggest, economic considerations as explanatory reasons for their motivation to migrate to the United Kingdom. Most revealing was the nurses, especially the females, considerations and expectations of the social outcome and value as economic and financial contributors not only to their immediate families but also to the

extended families. In West African society where communal responsibilities and well-being are sacrosanct, contributors to communal projects and supporters of events of communal and social significance are revered, therefore attaining such levels as the nurses carries high socio-economic responsibilities. With changes in social expectations and increased responsibilities, economic issues as a reason for migration of healthcare professionals, including nurses remain strong. The participants data revealed social considerations regarding women and marriages. The nurses' responses suggest they were being considered for marriages because they make greater economic contributions to their families.

“Whenever there is an occasion, you are the first person to be called on. So, what do you do even when they say you are woman but when you have money, they will respect you more than the man even? Even now, men want to marry you because you have money. Nobody wants to marry a liability. When a woman will stay at home and expect the man to bring food. Noooo it's those days not now” (Irene).

Further, the data suggest that, with most men relying on women to lay “success platforms” for them, a few of the nurses claim that their motivation to migrate to the United Kingdom was linked to keeping their marriages. This finding suggests that female nurses find migrating to the United Kingdom a way to ensure that their husbands stay with them, there is an expectation that working and living in the United Kingdom guarantee their spouses easy access to the United Kingdom visa.

“My dear, my husband pushed me into coming to the UK. You know, it is only nurses that can bring their husbands from Africa to this country. When nurses come over, their husbands are sure to come over too. But some nurses regret ever bringing their husbands over. I have a friend who suffered in the hand of the husband because he went and married another woman after getting his stay from her papers” (Ronke).

6.4.4: Theme Four: Personal and family social prestige

The data suggests the high social recognition West Africans place on people and families with their families abroad. As a status symbol, education and exposure through visits and residency abroad emerged as a strong motivational force for migration from the responses of the nurses on explaining the strong attachment to these assumptions in their home countries. The following quotes below reveal their mindsets and expectations.

“When people know that any member of your family is abroad, especially either America or England, it is a very big thing. People respect your family. It is not cheap to come to abroad, that is why. So, people think the family as very rich family and educated even if you don’t have much to show for it sometimes, that’s how we think and take it” (Azeez).

The participants responses suggest the feelings that working and further training abroad would not only enhance their economic relevance in their societies but would fundamentally raise their social statuses, too. This is consistent with the social assumptions that personal and family members’ level of association with Western education determines their social positions and classes.

“You know why my family gave me all the support; it is because of the prestige this will bring to our family. You will hear people saying about a particular family that, hmm, don’t play with family, do know how many of their family members are in ‘Ala Bekee’ (overseas)” (Mary).

The feelings and expectations of enhancing both economic and social statuses are great values but considerations of how and where these are sourced are also important. Much as nursing is considered by local standards in home countries as an above-average profession that can sustain families, being part of the privileged group that earns foreign currencies, these responses is viewed as suggesting a more elevated social status.

“In my country, we are proud of our achievements, even inside our families, we give respect to people who have achieved a lot mmm...and we look up on them as people that we can follow their footsteps. That is why everybody wants to move up every time. People that study abroad or live abroad, especially England or America are respected at home. So, we all want to go be in England” (Irene).

“Oh dear, we had problems...oooh... of where the money will come from (smiling) ...but sha...everybody came together because, in my place, we feel that once God helps anyone to go over UK, the person will be a big person” (Tina).

The participants data revealed a few other reasons that were mentioned by some of the nurses on why they migrated to the United Kingdom. These reasons were sparsely mentioned and did not run through most nurses’ responses. Therefore, they were not considered as substantially influential in the nurses’ decision to move out of their countries even though they represented facilitating factors. For instance, some of the nurses said that they considered the network of friends they have across Europe and the United Kingdom.

The nurses used these factors to consolidate their urges and judgments to migrate to the United Kingdom. The lure and attractions of being in the United Kingdom, even though they had not experienced it, increased their craving for the migration experience. Bose, as indicated in the following narrative, assumed that public perceptions of life in the United Kingdom were greatly exaggerated but she was not able to resist the temptation to move to the United Kingdom.

“My friends live abroad, and I always dream of living abroad too. When one of my friends visits home with her family, it is like, oh, look at her. Even if her skin is not good, everyone will feel it is the best skin because she came from overseas. So, I dreamt of it every time” (Bose).

This would also explain why, despite international collaboration to stem the tide in the number of international healthcare professionals from developing nations to developed nations, their numbers continue to rise. The urge to be part of the families whose members studied or worked abroad was found to be an influential nurses’ reasons to migrate.

6.5 Discussion (RQ1)

The insight provided into the nurses’ reasons for migration suggests that the nurses, like other skilled migrants in previous research, developed optimistic schemas both personally and professionally based on their expectations and motivations to migrate (Ken and Vico, 2015). One of the fundamental findings from the present study suggests that, contrary to earlier assumptions that economic considerations are fundamental to all migrants, West African migrant nurses had different generic reasons. The findings from the present study reveal four themes that explained expectations for the nurses’ migration to the United Kingdom. The

themes identified included the nurses' aspirations to improve skills and knowledge with the use of modern clinical technologies and equipment, aspirations to meet and improve their families' financial and material economies, aspirations to work in a safe work environment and aspirations to enhance personal and family prestige and social status.

6.5.1 Aspirations to improve skills and knowledge

The fact that most of the nurses feel that they were fully employed in home countries and could be classified within the above-average socio-economic bracket in their countries lends credence to their claims that searching for intrinsic job satisfaction drove their motivation to migrate. This challenges previous assumptions that economic reasons stand out for why migrants move from their own countries to new environments, especially due to deprivations. However, research also shows that the rate of development is not an absolute determinant of migration.

While it has generally been assumed (Castles and Miller, 1998; Todaro and Maruszko, 1987), that economic reasons were the dominant basis for migration especially for migrants from developing nations, the findings of the present study suggest West African migrant nurses reported various reasons for their migration to the United Kingdom. The findings therefore suggest that economic reasons were not the only reasons for the participants in the present research. Many of the nurses claimed they rejected offers of jobs with higher wages from other rich countries such as Qatar, Dubai, and Saudi Arabia. While it could be argued that language and communication barriers could have impacted the nurses' choice of migration destination, the findings suggest that the nurses were offered services of translators as medical professionals in the countries mentioned as part of their employment offers. Instead, the nurses desired to take advantage of the high training standards envisaged in the United Kingdom. While it is not evidenced from the current study data that the nurses downplayed the economic gains from their migration, the desire for training for enhancement of skills and knowledge was important for the nurses to sacrifice against high wages.

The nurses' explanations of desires to improve and expand on their skills and knowledge resonates with Wooldridge (2006) who argues that organisations and countries risk a drawback in their manpower capacity if they fail to embrace the global knowledge domain through travel across the world to acquire fresh ideas. Previous research (Adepoju, 2003) has returned reports of inadequate clinical infrastructure in most African countries. The nurses' data revealed their desires for the prospects of making a return migration, confirming their desires to return to their home countries after some time in the United Kingdom.

With previous employment in their home countries that placed them in above-average economic brackets before their migration, the nurses reported desiring more professional competence through engagement with state-of-the-art clinical facilities and technologies that were perceived to be present in the United Kingdom. The operational environments in their home countries which according to the nurses' accounts, were not fit for purpose, and the prospects of advancing skills and utilising modern clinical facilities in the United Kingdom, provided great push and pull factors. The findings are consistent with previous research that identified expectations of knowledge and skills improvement as some of the reasons why migrant medical professionals leave their countries (Alan and Larsen, 2003). When considered against the resource investment made in the nurses' migration bids, the findings stand to confirm the desires of the nurses to take advantage of the opportunity that their families could afford the cost involved in the processes. The findings which suggest the nurses' considerations of their future and careers are consistent with Kidd (2006) and Super's (1980) views that individual personal considerations and ideas would inform subjective choices in their later occupations. In contemporary careers choices, changing circumstances are argued to inform engagement with training and competencies in skills that determine an individual's career relevance for the future (Savickas, 2007).

In considerations and projections on future careers changes, the nurses anticipated that varieties of training opportunities in the UK in other areas of medical practice would prepare them for the later years of their careers. Their desires to re-join government services or end up in private practice, which emerged as one of the nurses' reasons to acquire advanced trainings and qualifications, is an indication that the nurses were not sure of what social and economic conditions they would end up with later in life. This also suggests that even with gains, material or otherwise from current employment, professionals still anticipate enhancing

and diversifying skills to prepare themselves for the future, hence the continuous prospects for migration to destinations which offer varieties of skills training.

These findings revealed feelings of apprehension amongst professionals in Africa and developing countries in general on their expectations on wellbeing after retirement from formal services and employments. This finding therefore reveals doubts on post formal work social conditions and wellbeing of professionals in developing countries. The nurses' intentions and expectations of further engagement in other careers, obviously in private practice after their formal careers highlights the risks involved with the lack of social protection safety nets in most developing societies, including West Africa.

In addition, the findings that training in highly valued environments such as the United Kingdom with its attendant prestige when applied in their home countries provided evidence to suggest that the nurses anticipated that would to return to their home countries. With expectations of a high level of respect and recognition in the home countries and opportunities for the educated, especially from western countries, the nurses' expectations to pick up sound work experience, education and probably reasonable financial acquisitions suggest a guarantee that they would plan to return. Many of the nurses believe that, following experiences in the United Kingdom, they would return to home countries because of the social values attached to studying or training in the United Kingdom which they plan to take advantage of in the latter part of their careers in their home countries.

The findings of this study represent both confirmatory and contrasting results to previous research and theories. While the fundamental reason for the migration of skills development contrasts with the arguments of developmental theorists (Gray and Johnson, 2008; Humphries, Brugha and McGee, 2009; Perrin, Hagopian and Huang, 2007; Smith, Fisher and Mercer, 2011) that economic disparity between developed and developing nations is fundamental to the decision to migrate, the current study found consistency with previous findings by Adhikari and Melia (2015) of migrant nurses' expectations of career progression and professional development.

The nurses' abilities to afford the cost of their migration to the UK demonstrates that they live within or above average economic brackets in home countries, hence the findings are consistent with Belloc's (2011) argument that sometimes the rate of development in a country can trigger

a strong motivation to migrate but for other reasons such as education, adventures, and skills acquisitions. These reasons provided a large incentive and drive for the nurses to migrate to the United Kingdom, an easy destination with abundant resources opportunities to enhance professional skills (Clarke, Crowe, Humphries, Conry, O'Hare, Kavanagh and Brugha, 2017).

6.5.2 Aspirations to sustain family economies and financial needs

While the current study findings on safety and wellbeing are consistent with previous research by Kirwin and Anderson (2018) which reported perceptions of defective systems as main drivers of migration from West Africa, there were also evidence for economic reasons in the nurses' data. Given the socio-cultural orientation of West African society with ascribed responsibilities to families both nuclear and extended, West African nurses reported economic expectations in their reasons to migrate to the United Kingdom. In a society such as West Africa where extended family systems play huge social roles, responsibilities are enlarged for those working in families. It is considered culturally and morally inappropriate and unacceptable behaviour for any working member of a family not to offer financial or other forms of material assistance to other members of the family, no matter how extended their relationship to the individual.

The nurses equally considered in comparative terms the financial and economic circumstances in the United Kingdom and West Africa, with the latter providing a strong opportunity cost in the nurses' decision (Yeates, 2010). This consideration was evidenced by the support of all members of the families to prospective migrants. The strong exchange rate of the United Kingdom currency helps sustain these aspirations. In comparative terms, the currencies of West African countries as developing nations do not compare strongly in economic terms to the United Kingdom's pound sterling. The multiplier effects of the strong exchange rate of sterling against West African countries' currencies formed a good appeal for the nurses and the support they had prior to their migration. This appeal has also been found to be strong in previous research (Humphries, Brugha and McGee, 2009; Odoemene and Osuji, 2015) and is consistent with the findings of the study by Geist and McManus (2012) that irrespective other reasons adduced for their migration, household incomes and earnings are increased by migration. The West African migrant nurses had intended to take up job offers on completion of their adaptation, hence justified expectations on economic rewards in financial earnings.

6.5.3 Aspirations to work in a safe work environment

Further to the expectations of acquiring necessary skills and competences and meeting material and financial responsibilities, the current study findings suggest the nurses as professionals' expectations to apply their vocations in safe working environments that offer them such opportunities. In perceptions of what constitutes a safe and ideal work environment, the nurses' data suggest that they value their views and contributions to be factored into their organisations decision-making processes which enhances their feelings of job satisfaction. The nurses' reports of the UK as a choice migration destination was partly on the grounds of anticipation of safe work environments that can allow their views and appreciate their knowledge and skills. These expectations contrast to what the nurses had experienced in previous home country work environments and feared in other suggested migration destinations that do not have open ,transparent processes. In their previous work environments that did not promote nor recognise personal skills but based rewards and opportunities on personal relationships and favouritisms, the nurses felt the need to leave for a much better environment.

In their home countries, the nurses reported acts that were inconsistent with worker well-being, such as cases of harassment and favouritism in the reward systems which the nurses considered not possible in a country such as the United Kingdom. The study revealed the nurses' anticipation and positive expectations to settle and work in a conducive environment not only to enhance their careers through predictable processes but also to achieve personal and work well-being. Dodge, Daly, Huyton and Sanders (2012) suggest that individuals' senses of wellbeing are positively related to physical, social, and psychological resources being available when needed for them to manage situations as they arise. The nurses' reports of not having the right clinical equipment ,in addition to their constant subjection to inappropriate harassment in some cases, added to their feelings of vulnerability which Karasek (1979) argues could lead to degrees of psychological strains.

In their perceptions of lack of regulated and enforceable employment policies and guidelines to protect employee rights in home countries, the findings suggest that West African migrant nurses saw the United Kingdom as a credible alternative as a well-regulated work environment that could guarantee their well-being. Scholars Conway and Briner, (2002), Morrison and

Robinson, (1997) and Pugh, Skarlicki and Passell, (2003) argue that employee perceptions of a work environment that safeguards their interests predict less feelings of organisational cynicism and intentions to leave. Similarly, Eisenberger, Huntington, Hutchison, and Sowa (1986) and Shore and Wayne (1993) suggest that organisational support for employee well-being and appreciation of employee contributions has a positive impact on employee involvement and reduces turnover

6.5.4 Aspirations to enhance personal and family social prestige .

Further findings of the study are that there is collective responses and support for the nurses' migration ambitions from family members. This was found to be related to high expectations for the prestige and honour that their society places on families whose members are abroad, either working or studying. The high social valuation of their families following migration to the United Kingdom contributed to the nurses' husbands' endorsement of the move. This is significant, especially in a society where married women are not expected to stay away from their families and be on their own (Oduyoye, 2001; Phiri, 1997). This is a new insight from the study that migration raises nurses' profiles within their families and for single nurses, migration to the United Kingdom provides a strong factor in getting into marital relationships.

The new insight generated from this finding leads to an expansion of understanding that families support a would be migrant not only because of the financial return on investments (De Hass, 2010; Massey, Arango, Hugo, Kouaouci, Pellegrino and Taylor 1998; Todaro and Maruszko, 1987) but also for the long-term expectations that there would be an improvement in their social standing. There were expectations of pride for all members of the family, some of whom may not even benefit materially from the journey. In traditional African societies, family members demonstrate a sense of collective responsibility on matters they consider of communal benefit and nature (Drinkwater, 2002; De Haas, 2010; Massey and Espinosa, 1997; Ogunsiji, Wilkes, Jackson, and Peters 2012; Papapanagos and Sanfey, 2001).

6.6 Implications of Study One

The findings of Study One suggested four main themes that described reasons for West African migrant nurses' migration to the United Kingdom. These reasons consequently informed the nurses' expectations of achieving upward labour mobility, job satisfaction and well-being as well as positively impacting both their personal and family socio-economic well-being. The nurses' expectations, therefore, are summed up as obtaining essential values from both intrinsic and extrinsic rewards from both migration and work (Botsford, 2009; Hazell, 2010).

6.7 Mapping link between Study One and Study Two

In Study One, the researcher examined the reasons and expectations that West African migrant nurses' use to explain their migration to the United Kingdom. These findings suggest that West African migrant nurses have basic optimistic objectives, both personal and professional, that informed their motivation to migrate and their expectations of migration to the United Kingdom. Previous studies, including (Withers and Snowball, 2003) revealed limitations in their articulations on what constituted migrant nurses "unmet expectations"(Alexis and Vydelingum, 2005).

In the present research, the nurses' expectations were based on their personal and professional schemas (Ken and Vico, 2015). Consequently, it is likely that these expectations shape their cognitive evaluation of experiences at work (Abu Dole and Hammou, 2015). With the researcher's understanding of the nurses' expectations of migration to the United Kingdom, the second study considers the nurses' actual experiences. Previous research on migrant nurses in the United Kingdom suggests that they had negative experiences at work. It is therefore not new to suggest that migrant nurses report negative experiences at work; what remains to be explored is how the nurses' cultural conceptions might explain their perceptions of their experiences as well as how they managed under the circumstances. In Study Two, the researcher, through reflective interpretative engagement with the nurses' interview accounts, examined how the nurses' cultural conceptions might explain their perceptions of processes at

work and the actions of their managers and colleagues at work. Further, the researcher examined the nurses' responses and how they coped in the context of their circumstances.

Chapter 7: Study Two

Research Questions 2 and 3, as examined in Study Two of the research, were: *How might cultural conceptions explain West African migrant nurses' perceptions of experiences at work in the United Kingdom?* and *How do West African migrant nurses manage conflicts between their expectations and experiences?*

7.1 Data collection

The main source of data for Study Two of the research, as in Study One, was semi-structured interviews with the same (N-15) West African migrant nurses. Each of the participating nurses was interviewed in a one-to-one, face-to-face setting. Each interview session lasted approximately (55) minutes except for two nurses, whose interviews lasted 75 minutes. These interviews had a few interruptions when the nurses concerned took calls from their workplace or home countries and asked to be excused to take the calls.

The researcher allowed these interruptions and observed that, in answering calls from work, these nurses displayed anxiety. When the researcher inquired further about their apprehensive temperament during the calls from their workplaces, the nurses revealed that most calls from their workplaces, especially when they have left work, relate to queries about what they have done wrong or failed to do.

As a preliminary step into the interviews, the researcher prompted each of the nurses to explain their current role and to say whom they interact with most frequently at work. The nurses identified their roles as registered nurses who work in nursing homes and carry out tasks as "nurses in-charge." They oversee other care staff and are answerable to their home managers, so they have working relationships with both their managers and colleague caregivers.

7.2 Interview guide

The interview for study 2 focused on the nurses' experiences at work, and particularly their interactions with their managers and co-workers. This is where conflicts in cultural values, expectations and experiences are most likely to occur. Asking the nurses to recount significant experiences of events or interactions at work and to reflect on their experiences and feelings about them, should surface deeply held assumptions about the interactions and perceived appropriate behaviours. To probe the issues, the researcher used an interview guide to remind him of the topics to be covered but the nurses were encouraged to freely express their thoughts and feelings as the aim was to capture verbatim lived experiences.

The run-up questions before the main guide question enabled the researcher to explore through the nurses' own understanding: *who they interact with at work, how important the relationship with their managers is to them, the impact of perceptions of experiences and interactions at work, coping strategies within and outside of work*. The aim of these questions was to position the nurses' working relationships and how they impact their feelings and responses at work. To generate enough of the nurses' thoughts on what the research is exploring, the researcher encouraged the nurses to talk about the actions and behaviour of their British managers and colleagues at work that affected their thoughts and emotions. These would involve the nurses' perceived actions and behaviours, which are thought to be emotionally important in relation to the nurses' value expectations in their interactional relationships.

The interview guide for research Questions Two (2) and Three (3) included: *How important is your interactional relationship with your manager and colleagues to you? Tell me about actions or behaviours of your manager or colleagues at work which impacted on your thoughts and feelings*.

In the context of the research question on the role of cultural conceptions, the researcher deliberately avoided posing interview questions that referenced culture directly because such questions could be leading. Instead, the researcher aimed to use data about the nurses' perceptions of processes, actions, and behaviours to reflectively explore how the nurses' cultural conceptions might explain their perceptions. Participants were further probed to explain their responses and attitude to work in the context of their perceived experiences so that the researcher could reflectively explore how the nurses made sense of the situation.

Finally, through probing, the nurses were encouraged to express how they managed under the circumstances to keep carrying out their duties as well as maintaining their future hopes and plans of working in the United Kingdom. Further probing questions were posed to understand the immediate feelings and responses in the light of their perceptions: *Can you tell me how such actions and/or behaviours made you feel in terms of your emotions and reactions at the time?* On research Question Three (3), which examined how the nurses managed conflicts of expectations and experiences, the following question was used: *How would you say those actions and/or behaviours of either your manager or colleagues affected you and how you do your work?* This question was meant to examine both the proximal and distal impact of the nurses' perceptions of events and the actions of their managers and colleagues at work. Further probing questions enabled the researcher to gather data on the nurses' choices of actions. The researcher sought to explore how participants coped with their experiences, hence the following: *Given your emotions on perceived actions of your manager or colleague, tell me how you manage to continue to stay on to do your job; do you still hope to continue to work in the UK as a registered nurse?*

7.3 Analysis of data

The choice of a research method and analysis depends on the overall objectives and questions of the research (Symon and Cassel, 1998). Social realities are characteristic of the development of schemas that are applied within the context of persons' interactions with fellow human beings (Patton, 2002). Research suggests that migrants' cultural attributions could moderate their sense-making of social and organisational environments (Babatunde- Sowole, Jackson, Davidson, and Power, 2015; Berry, Poortinga, Segall and Dasen, 1992).

To inform insight into the migrant nurses' experiences, the researcher examined how cultural conceptions might explain their perceptions of processes, actions, and behaviours as part of their interactions at work (Golafshani, 2003). The researcher focused on West African migrant nurses as culturally embedded people and sought to understand the stories of their work experiences through reflective awareness of their subjective perceptions as they engage with their managers and colleagues as the world around them (Van Manen, 1997).

In understanding the nurses' stories and perceptions at work in relation to their cultural conceptions, the researcher applied data collection and analysis methods which are not only

likely to provide rich first-hand participants' accounts but also allowed the researcher's involvement in uncovering hidden meanings in the nurses' perceptions (Beck, 2009), hence the choice of the method of interpretative phenomenological analysis. The interpretative phenomenological analysis (IPA) is influenced by the hermeneutic version of phenomenology. This method was chosen because it involves interpretations of perceptions. In doing this process, the researcher enquires and identifies deeper patterns of meanings within individual accounts and across the total nurses' accounts as they relate to their cultural conceptions. The researcher examined the nurses' data interactively and through reflective interpretations, meanings were attached to what these mean for the nurses in relation to the research questions (Smith, Flowers, and Larkin, 2009).

The phenomenological analysis becomes an appropriate tool of inductive analysis when the study aims to examine data and construct the meanings of perceptions and experiences that involve reflective judgments (Bryman, 2001; Moustakas, 1994). The technique provides the process and platform for the researcher to gain further insight into participants' accounts. The researcher, through rigorous data familiarisation and an inductive approach, develops themes of meanings from the participants' interview accounts (Moustakas, 1994; Willig, 2008).

7.4 IPA and organisational behaviour research

Interpretative phenomenological analysis is a new and not widely used technique in organisational psychology and organisational behaviour disciplines. (Gibson and Hanes, 2003; Conklin, 2007). In this respect, despite its increasing popularity in exploring and examining lived experiences, interpretative phenomenological analysis (IPA) has been subjected to queries about its adoption in research (Gibson and Hanes, 2003; Conklin, 2007).

Giorgi (2010) argues that IPA as a research analysis technique not only lacks intersubjective steps and raw data accountability but that it is prescriptive. This implies that the meanings assigned to events by individuals can only be clear through the interpretative engagement of the researcher (Biggerstaff and Thompson, 2008). Interpretative phenomenological analysis, even though it can create insights, does not establish absolute reality in its findings and could generate multiple explanations (Yardley, 2000).

However, in recent times, IPA has gained ground within the academic research community of organisational behaviour and psychology. It has been applied in research to analyse and understand issues in organisational contexts as in the following research works (Adams, Shakespeare, and Armstrong, 2015; Antoniadou, 2013; Gill 2015; Howe-Wash, 2010; Medhurst and Abrecht, 2016; Santos, 2016). Qualitative research techniques, including IPA, aim at enhancing understanding and generating insight and are not intended to create objective knowledge (Maxwell, 2002). In using IPA, subjective accounts of participants are considered through deep reflective analysis by the researcher. This is to evolve a deeper understanding of the thoughts and feelings of participants concerned in the context of the research questions.

Smith (2010) argues that interpretative phenomenological analysis in research relies on ordered and detailed processes of data collection and analysis that, when followed by the researcher, enhance the validity of its findings. The researcher, in using interpretative phenomenological analysis in the present research, ensured the integration of IPA's theoretical principles of hermeneutics and idiographic analysis by following the series of steps recommended by Smith, Flowers and Larkin, (2009). In doing this, the researcher ensured that the verbatim quotes from participants were included in the process of analysis. This was necessary to avoid researcher biases because of preconceptions and beliefs. This is consistent with the advice from Smith, Flowers, and Larkin (2009).

‘The analyst maintains an open mind and notes anything of interest within the transcript...this is likely to describe the things that matter to them: key objects of concern such as relationships, places, events, values, and principles’ (Smith, Flowers, and Larkin, 2009:83).

“The analytical process begins with the detailed examination of each case ...and cautiously moves to an examination of similarities and differences across cases, producing fine grained accounts of patterns of meanings for participants reflecting upon a shared experience” (Smith, Flowers, and Larkin, 2009: 38)

7.5 IPA: Inductive, interrogatory, and reflective processes

The IPA is an idiographic process. The idiographic understanding with this process suggests that the researcher starts with a single case of the participants and focuses on the personal, unique experiences of the individual before moving through the other cases and treating each case in the same way. In this way, thematic convergences and divergences across all participants' accounts are established. Each individual participant's account is read and re-read separately, and extracts are collected to be used to inform descriptive themes. This initial step shows the aggregation of information and identifying data that inform the descriptive themes that are generated (Creswell, 2007).

In Study Two of the research, the researcher collected data from the West African nurses' stories as subjective accounts. The participants' accounts were examined and reflected upon to determine what the nurses' perceptions of actions and behaviours of their managers in their work interactions might indicate about their cultural conceptions (Biggerstaff and Thompson, 2008; Smith, Jarman and Osborn, 1999; Snape and Spencer, 2003). In this way, an understanding of what these perceptions represent for the nurses in relation to their cultural conceptions are evolved as insights.

According to Smith, Flowers, and Larkin (2009), the interpretative phenomenological analysis involves double hermeneutics. The researcher obtained the participants' individual interview accounts as the primary data and, through an inductive process, carried out data familiarisation of each nurse's account (Moustakas, 1994; Smith, 1998; Smith, Flowers, and Larkin, 2009; Walsham, 1995). Afterward, the researcher recorded any comments from individual nurses that reflect meaningful links to the research questions. In the same way, the researcher used reflective interpretative processes to cluster already generated descriptive themes into higher-order codes of superordinate themes.

7.6 IPA: Hermeneutic theory of double interpretations

Interpretative phenomenological analysis (IPA) is influenced by the hermeneutics theory of double interpretations (Smith, Flowers, and Larkin, 2009). This involves the researcher's initial consideration and familiarisation with the participants' primary interview accounts. In this case, the nurses' feelings about experiences and the researcher's second process of reflective

constructions of meanings and shedding light on the participants' perceptions. While IPA processes allow for an understanding of the meanings' that participants attach to their experiences, it also allows the researcher to make further sense out of the participants' perceptions of their personal and social world (Rees, 2011). In using interpretative phenomenological analysis, the researcher engaged to effectively interpret the nurses' accounts of their experiences to understand the underlying circumstances and inherent meanings (Moustakas, 1994)

“The IPA ... recognises that access to the experience is always dependent on what participants tell us about that experience, and that the researcher then needs to interpret that account from the participant in order to understand their experience” (Smith, Flowers, and Larkin 2009: 03).

The researcher considered the participants as important group in this research because of their input of their thoughts about their experience that are used to construct deeper interpretations (Stawarska, 2009). Interpretative phenomenological analysis relies on the depth of data that the nurses provided through their interviews, which form the very foundation for further analysis and interpretation. However, in the manner of the researcher considering the participants as co-researchers whose accounts of their inner worlds of experiences are being considered, their interview accounts as transcribed data ready for analysis were sent back to the participants to ensure that the input for analysis accurately represents their thoughts and stories. In this way, the participants were encouraged to make further comments and corrections as appropriate in the transcriptions, ensuring the accuracy of the original data.

Upon satisfaction with the accuracy and details of data, the researcher through interpretative reflective interpretation and construction moved the data from what the participants perceive of their experiences to what these could mean in relation to their cultural conceptions (Pringle, Drummond, McLafferty and Hendry, 2011). The researcher's reflective interpretation of the nurses' interview accounts was therefore critical for identifying potential underlying meanings regarding the nurses' perceptions. This is because IPA allows for the researcher's involvement in exploring deeper meanings through reflective analysis of perceptions of actions and behaviours in interactions and experiences (Holstein and Gubrium, 1994; Langdridge, 2007; Smith and Osborn, 2003; Todres and Holloway, 2006).

7.7 IPA: Present research processes of analysis

7.7.1 Process Stage One (Preparing the data for analysis)

The researcher carefully transcribed all the audio-recorded interview accounts verbatim (Maxwell, 2005; Smith, Flowers, and Larkin, 2009). This ensured that further reflective interpretations of the nurses' perceptions are grounded in the nurses' raw data accounts. The digital interview recorder used during the interview had built-in software to auto-transcribe the nurses' interviews. However, this was not after all possible as a result of difficulties due to the tool not recognising some of the participants' accents easily. Manual transcriptions (Webb, 1999) therefore, became necessary and were used. The researcher had a pre-warning about this because it was one of the earlier challenges from Study One. The researcher, therefore, allowed ample time to engage with the manual transcription of the audio recordings into texts during Study Two.

While this seemed an initial challenge and disappointment, the manual transcription on its own proved useful because it enhanced the researcher's deep immersion into and familiarisation with the data even before analysis. It provided a good opportunity for the researcher to develop a deep appreciation of the words used by the participants and the context in which these were used. The researcher, during this exercise of manual transcriptions, listened keenly and, in the process of listening to the accounts of the nurses, was able to identify both rising and low tones as well as emotive dimensions and emphasis on some keywords and expressions by the nurses. This helped to generate deep insight into what these words could interpret for the nurses in their interactional relationship at work. To maintain the nurses' personal and organisational anonymity, each of the nurses was assigned a pseudonym instead of actual names.

7.7.2 Process Stage Two (Coding the data)

The researcher engaged in reading and re-reading the individual nurses' transcribed interviews. During this stage of free textual analysis, the researcher identified keywords, phrases and statements of essential quality and coherent meanings with the potential to form relevant issues of analysis regarding the research questions (Smith and Osborne, 2008; Hycner, 1985). The researcher focused on keywords and phrases that tended to reflect on issues of in organisational

processes, appreciation of values and coping (Creswell, 2007). The researcher identified keywords, phrases and sentences in the transcripts that relate to patterns of thoughts and interpretations leading to emotions linked to values. These particularly relate to the nurses' expectations and experiences of values in the actions and behaviour of their managers and colleagues at work. (Eaton and Smith, 2008; Smith, Flowers, and Larkin, 2009; Smith and Osborne, 2003). The analysis was subjectively informed by an understanding of Hofstede's analysis of cultural values in West Africa but not limited to his dimensions. The researcher organised the keywords and phrases in electronic format and saved to the researcher's password-protected personal computer. This method provided easy access and references.

7.7.3 Process Stage Three (Generating the descriptive themes)

With keywords, phrases and statements identified from the nurses' interview transcripts, the researcher engaged in the first sense making (reflective interpretations). This involved the researcher evaluating how the words from the texts could be interpreted. The researcher's initial deductions from these keywords, phrases and statements were to generate patterns of meanings as descriptive themes relating to the research questions.

'This involves an analytic shift to working primarily with the initial notes (margin notes) rather than the transcript itself ... the process of identifying emergent themes involves breaking up the narrative flow of the interview. This process represents one manifestation of the hermeneutic circle' (Smith, Flowers and Larkin, 2009:91).

Of interest were accounts of the nurses' interactions at work that seemed emotionally significant as these offered insights into their expectations and values about work relationships. From the initial process of the researcher's familiarisation (reading and re-reading) each nurse's interview transcript, the researcher identified key words, statements and sentences that were considered relevant to the research questions on cultural conceptions and managing conflicts of expectations and experiences. At this stage, the researcher generated the initial reflective descriptive themes (Smith, Flowers, and Larkin, 2009). These represent the researcher's first-stage sense-making, reflective analysis of the nurses' perceptions of the processes at work, actions and behaviours of their managers and colleagues in relation to the

nurses' value expectations. The researcher's initial sense-making, reflective analysis of the keywords, phrases and sentences also reflects IPA's combination of phenomenological and interpretative (hermeneutics) epistemological underpinnings.

The researcher created a table relating the keywords, phrases, and sentences to descriptive themes. These keywords explain the extracting relationship between the nurses' perceptions in relation to the research questions. For instance, keywords, phrases, and sentences such as "not me to challenge," "did not complain," "don't want wahala" were reflectively informed to the concept of "avoiding conflicts" or "passive response" Further keywords, phrases and/or sentences, such as "did not ask my permission," "nurse in-charge," "she is the boss" informed a reflective descriptive theme as "concerns on power relation" In this way, the researcher initiated the co-sense-making partnership in understanding the nurses' subjective perceptions through reflective inductive explorations of their interview accounts (Lewis and Zibarras, 2013; Smith and Osbourne, 2003). The descriptive themes were kept as close as possible to the original nurses' core data in thoughts and accounts but showed the first-level interpretation of their perceptions of their experiences and responses.

7.7.3.1 Case by case analysis of individual nurses data

The researcher used the first participant's interview account to analysis and generate the initial descriptive themes for each of the research questions. For interpretative phenomenological analysis, *"One possibility is to use the master theme list from the first interview to begin your analysis of the second, looking for more instances of the themes you have identified from the first interview but being careful to identify new one that arise"* (Smith, Jarman and Osborn, 1999:224).

Having set the initial descriptive themes from the first participant's data, the researcher carried out a case-by-case analysis of the remaining fourteen nurses' transcripts to identify possible similar data but with keen attention to identifying new themes from the other nurses' accounts. In this way, the researcher, in analysing each nurse's data, kept an open mind for any contrasting or new issues that might arise from any of the other nurses' interview accounts in the transcripts.

The researcher considered keywords, phrases, and sentences for inclusion in the descriptive themes if found in at least half or two-thirds of all participating nurses' transcripts to increase the validity of findings (Smith, Flowers, and Larkin, 2009; Watson, McKenna, Cowman and

Keady, 2008). In the present analysis, the researcher considered words, phrases which appeared in varieties but similar feelings in at least ten of the nurses' interview accounts, representing approximately 67 percent of the participants. In reading through the nurses' interview accounts, the researcher checked if any of the already generated themes needed recoding. For any of the keywords, statements, or phrases to be included in the initial descriptive themes, the researcher ensured that they were persuasive enough within the contexts in which they occurred to make sense (patterned meaning) of the nurses' perceptions across most of their accounts. In the researcher's interpretative reflective analysis of the nurses' data, patterned meanings were used to describe similar meanings across the nurses' interview accounts in their perceptions of experiences at work. The keywords, phrases and sentences identified in the nurses' interview texts and used to generate the descriptive themes within each superordinate themes are presented in tables 8.1 to 8.6 of the finding's section of the thesis.

7.7.3.2 Participants' profiles

Joke (F) is 50 years old. She arrived in the United Kingdom in 2005, having trained and practiced as a nurse in her home country for 10 years. A mother of four children, Joke had initial considerations for migration to either Qatar or Saudi-Arabia but changed her mind. . She is the breadwinner in both her maiden and marital homes back in her home country. Joke continues to maintain ties with her family back in her home country. Joke claims she has no intention of returning to the home country.

Adama (F) was 42 years old when she arrived in the United Kingdom to start her career as a nurse. Adama worked in her home country for a couple of years before migrating to the United Kingdom. She qualified as both a general nurse and a midwife in her home country but intended to specialise with additional training in the United Kingdom. Adama is married and has three children and is currently on a work visa. Adama works currently in a nursing home but does

other extra duties in other care homes through agency placements. Adama has no immediate plans to return to her home country.

Azeez (M) is 45 years old, married and has three children. His journey as a nurse started with a career change from teaching in his home country in West Africa. Azeez retrained as a nurse because he wanted an avenue to further train as a medical doctor. The desire to further train as a doctor is still in Azeez, even though he is considering the cost and his other responsibilities back home in West Africa. Azeez had planned to finish his higher studies and possibly transfer his services back to his home country where, according to him, such services would be most needed in view of the appalling ratio of patients and doctors in his country.

Bash (M) is 42 years old and worked in in his home country before migrating to the United Kingdom. The work environment in his home country forced him out of the country. Bash had strong motivation to migrate to the United Kingdom because of the stories he heard about the successes of nurses in the United Kingdom and the conducive work environment. Bash did not convert to start practicing as a registered nurse immediately after his adaptation program. He was first engaged as a senior Carer before being employed as a registered nurse.

Tunde (M) is 46 years old. He aspired to pursue an initial career in nursing, hoping to proceed finally to train and qualify as a medical doctor. Tunde's reason for migrating to the United Kingdom was to improve on his career and achieve his heart's desire of becoming a medical doctor. Tunde's family of wife and three children are still living in his native country in West Africa. Tunde plans to continue to work to earn his British citizenship. He believes that, since he may not be able to achieve his initial desires of retraining and qualifying as a medical doctor, he will work toward bringing his wife and children over to the United Kingdom.

Bose (F) 38 years old, came over to the UK a few years after practicing as a nurse in her home country. Bose's initial plan was to come over to the UK, work, save and possibly advance her nursing career with additional qualifications. Bose currently plans to take up residence but is increasingly worried about her marriage. Bose is very conscious of the position of her native society on issues of marriage, which within her society is sacrosanct. This is given the level of

social stigma that women without husband and children face in her native country. Bose has no immediate plan to relocate to her home country

Tina (F) 48 years old, is the first child in her immediate family of five and is married with three children. She grew up taking care of her younger siblings, who still look up to her for support even though she is now married. She also takes care of her aged parents and her parents-in-law. She grew up in a rural community and trained and worked as a nurse for a couple of years in her country before she decided to relocate to the UK following very “comfortable” paintings of the UK’s working and living environment by her friends.

Jenny (F), 52 years old worked and rose to the position of matron in her native West Africa. In that role, Jenny managed over 30 nurses and other paramedical staff. She had initially planned to stay a few years in the UK and move on to the United States. She had contemplated moving back to West Africa on several occasions, but she has always been encouraged to stay in the UK by her family members back home. According to her, this is because of the social status attached to training, living, and/or visiting overseas, especially England and America.

Ronke (F) 43 years old, has always dreamed of charting a career course overseas. Ronke was quite passionate about the United Kingdom, having lived all her life in West Africa and hearing stories about life in the United Kingdom. Ronke explained her experiences so far as a practicing nurse in the UK as that of mixed emotions because she has had her ups and downs. Ronke has no plans of returning to her home country as at yet. However, she is satisfied with the contributions she is making to her family and community through her financial remittances. Ronke is currently sustaining all these because of her engagement in multiple employments in addition to her job.

Joyce (F) qualified as a nurse /midwife in her home country. She worked for several years before deciding to migrate to the United Kingdom. Her passion for nursing further sustained her urge to work in the United Kingdom. Joyce’s joy in migrating to the United Kingdom was also a result of her experiences and encounters with her countrymen and women who had either studied or worked previously in the United Kingdom. Joyce, 52 years old, considers herself a resolute woman who has a remarkably high threshold for tolerance. Joyce is married to a medical doctor who is currently practicing in her native country. She grew up in her native

country in West Africa but cherishes some of the values she found in the UK. Joyce does not intend to return to her home country now.

Mary (F) is 47 years old. Mary started her early career as a medical health assistant in one of the military hospitals in her native West Africa. Mary suffered emotional pains with the death of her husband and the unpleasant experiences she suffered in the hands of her in-laws after the incident. While she was being denied complete access to her husband's property by her brothers-in-law, she was also being subjected to extremes of financial bullying. Mary was not able to bear the situation. Mary says there was not much to be jubilant about so far regarding experiences at work, but she was not planning to leave work or the United Kingdom because options are limited.

Mam (F) , 49 years old, was born into a polygamous family with her father's marriage to two wives. Mam was the first child in her family with eight other female siblings. The father decided to marry a second wife with kinsmen's pressure because the mother could not bear him a male child. Initially, she was almost left uneducated because there was such an assumption in her native place that "training or educating a woman is pointless because she will end up being another man's property as wife." It was that burning desire to project herself as a role model that made her look into getting to the UK. She intended to enhance her career and possibly to enter public service to champion the course of the girl child in her native West Africa.

Irene (F) 44 years old, earned her B.Sc. in nursing in a university in her native West Africa and had practical work experience at home before migrating to the UK. She applied to work in the United Kingdom like most other nurses through internet searches and was encouraged by her husband to get on with the processes. Her life and work experience in the UK has brought mixed feelings. Irene believes that her relationship and link with her family back in West Africa remains strong. Her migration to the United Kingdom was more of an adventure and sustenance of family social status. Irene has no plans of returning to her home country now.

Amie (F) , 48 years old, trained and practiced as a general nurse in West Africa. She likes education and desired to improve on her original nursing qualifications. Amie was not particularly sure of what she wanted to improve upon in terms of her professions, but she felt that coming to the United Kingdom would provide a lot of career development opportunities. Amie had a good experience during her adaptation program because she worked under the guidance and mentorship of a senior black nurse. Amie has also enjoyed her stay in the UK, although she acknowledges that she has had times when she contemplated moving back to Africa. Amie has no plans for an immediate return to her home country.

Peace (F) is 52 years old. She has been working and living in the UK without any member of her family. Peace migrated to the United Kingdom some ten years ago because it was tempting for her then in terms of the economic benefits and the high level of social recognition and prestige it promised and indeed offers back home. Peace as at the time of the interview was not feeling well and was planning to ask her manager to review her workload. Peace has on several occasions thought of going back home but on such occasions, she had also thought about her dependents and what people back home will think of her.

7.7.4 Process Stage Four (Clustering of themes)

At this stage of the analysis, the researcher did a deeper reflective interpretation. This involved his interpretive reflective clustering of the descriptive themes to form higher-order categories called the superordinate themes. Through iterative reanalysis of the texts to get deeper reflective insight on the connections between these words, phrases and sentences and the nurses' perceptions, the researcher clustered the descriptive themes in the contexts of the participants' responses to define a pattern of meaning that underpinned a central theme in relation to the research questions. The superordinate themes that emerged, therefore, represented the researcher's interpretation and clustering of the descriptive themes through the interpretative reflective activity of determining within which context the nurses used them (Creswell, 2007). In determining these higher-order superordinate themes, the researcher repeatedly checked back on the nurses' interview accounts to ensure that the researcher's reflective interpretation of the nurses' perceptions was grounded in the original texts and has links to the research questions.

For instance, when participants had used words or phrases such as "family issues," "brother's keeper," "work as sisters," etc., these were interpreted with respect to family values that would emerge as descriptive of them. Where participants had used social-related or relational emotive comments, these were identified and interpreted into descriptive themes. Further deeper reflective interpretation and clustering of these descriptive themes would result in higher-order superordinate themes. Fig (7.1) below shows the researcher's familiarisation with the data, identification of keywords, phrases and sentences and generation of concepts as descriptive themes and a further, deeper, reflective exercise to generate analytical superordinate themes.

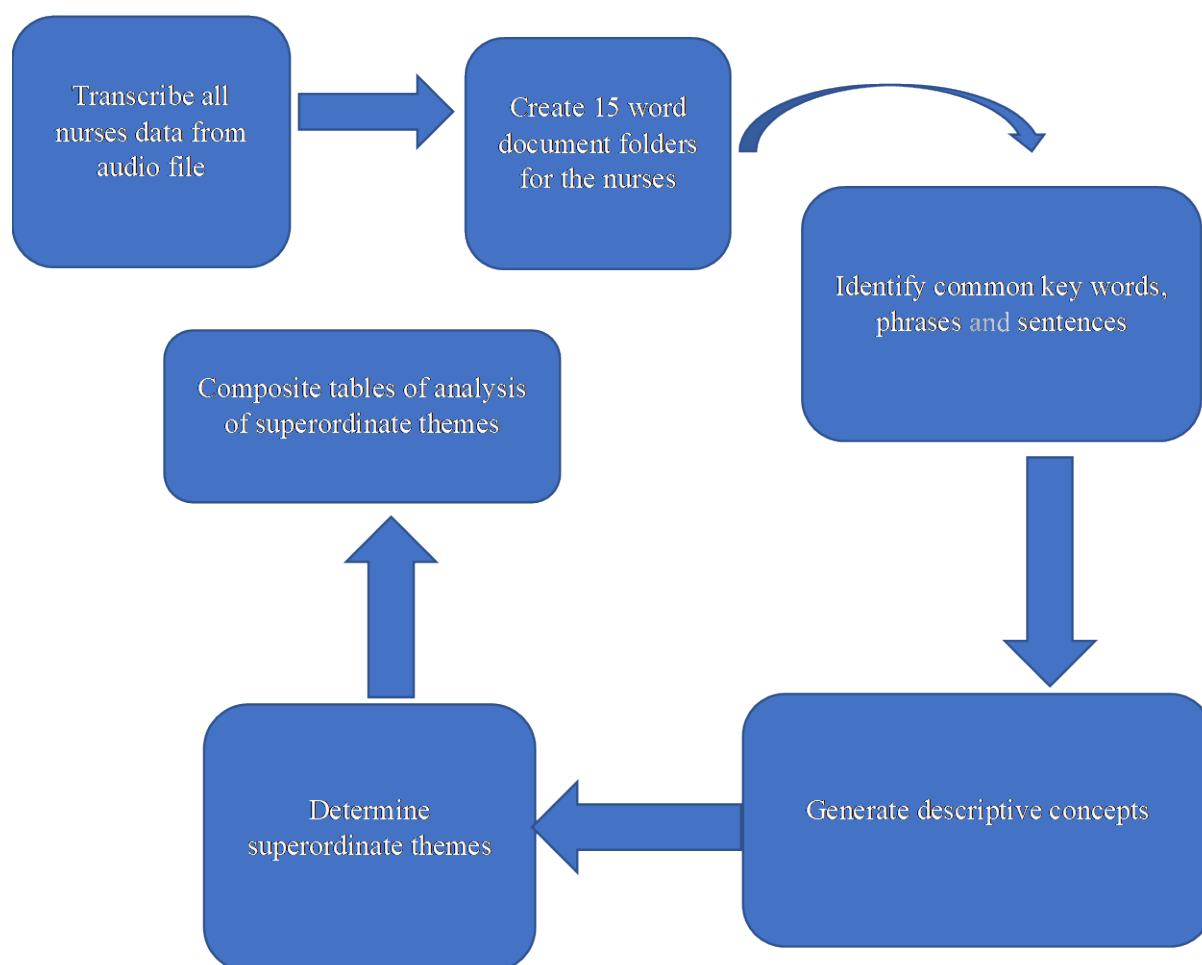


Fig 7.1 Process of organisation and analysis of data (Study Two)

As shown in Fig 7.1 above, in organising the initial identified keywords and/or phrases from the nurses' interviews, the researcher had the option of organising them by the side margins of the individual nurses' transcripts. This is a conventional way of doing it. One of the good arguments for this approach is that it provides an easy reference to the original context in the interview text from which they were extracted. However, in the present research, the researcher chose the option of organising them electronically. The researcher, while reading through each transcript in a word document opened a blank word document in a double document view. The researcher read from individual nurses' original transcript to identify keywords, phrases and sentences relevant to the research question under consideration. These were highlighted using an electronic colour highlighter and copied into the new blank word document and later saved

in the relevant nurse's already existing folder on the researcher's personal computer. In that way, each of the fifteen nurses has keywords individually saved in their individual electronic folders. The advantage of this option is that, instead of using hard copies of the transcripts and identifying keywords on each side of the copies, the researcher held all transcribed nurse responses in word documents on the researcher's password-protected personal computer. In this way, the chances of losing documents and exposing data on hard copies were eliminated. Holding the electronic version of the data also helped for easy access, referencing and management of the data.

After the analysis of the individual nurses' interview accounts and the collaboration of the themes across all accounts, the researcher compiled the final list of superordinate themes, which became the findings of the study. At this stage, drawing further on existing theories and literature, the researcher went back and forth across all the nurses' interview data to re-examine contexts and produce a theoretical explanation (Eisenhardt, 1989; Smith, Flowers, and Larking, 2009; Smith, Jarman and Osborn, 1999; Yanow, 2004) of the nurses' perceptions of experiences at work, responses as a result and their coping strategies both in and outside of work. This level of analysis also reflected the synthesis of the double hermeneutics process indicating the researcher's involvement in creating insights on how cultural conceptions might explain West African migrant nurses' perceptions of their experiences at work.

7.8 Summary of the data analysis processes

Study Two of the research aimed to explore how cultural conceptions West African migrant nurses' might explain their perceptions of work process actions and behaviours of their managers and colleagues at work. It equally examined how the nurses managed conflicts between their expectations and experiences in terms of coping under the circumstances. In evolving these insights, the researcher used an interview guide to collect the nurses' stories as the primary data. The researcher transcribed, coded, and analysed these through a reflective interpretative process.(Mann and Abraham, 2006; Moustakas, 1994).

The analysis of data determining the findings in this research was based on interpretative phenomenological analysis (IPA) (Smith, Flowers, and Larkin, 2009). While Smith, Flowers, and Larkin (2009) stated that there is no standard prescription for the analysis and presentation of an interpretative phenomenological study, in the present research, the researcher provided a

detailed description of the process of how the defining themes, both from individual nurse's data and across the nurses' data sets, were generated to enhance the validity of my findings. The data collected from the nurses whose experiences are being studied were detailed. In the process of reading the data, the researcher identified concepts relating to keywords, phrases, and sentences to the research questions.

The researcher ensured that all accounts of analysis were rooted in the nurses' interview accounts representing their original data (Spence, Ritchie, and O'Connor, 2003). In generating the descriptive themes, the researcher used the first participant's data to set up the initial themes and later analysed each individual nurse's interview transcript in case-by-case basis and identified patterned meanings or similar senses of meaning in the contexts within which the participants expressed their thoughts. The participants' contextual thoughts were collated across all accounts and later merged into a group list of analysis (Eatough and Smith, 2008; Van Kaam, 1966). The researcher's in-depth familiarisation with the nurses' data representing their lived experiences led to the production of the meanings of their perceptions, not only as individuals but also as a group (Creswell, 2007; Larkin, Watts, and Clifton, 2006; Malterud, 2001).

The researcher used a similar process for the other parts of the remaining questions on the nurses' management of conflicts of expectations and experiences and how they coped. The researcher further engaged the analysis of the data with extant literature in the discussion chapter of the thesis which were used to generate deeper insight into how cultural conceptions might explain the nurses' perceptions of experiences at work and how they managed and coped under the circumstances.

7.9 Challenges of the processes

The problem and disappointment anticipated from automatic transcription mentioned in a previous section of the thesis above were first addressed with the researcher engaging the help of two of his colleague research students, who helped to manually transcribe a few of the interviews and checked that others were transcribed correctly. Another challenge in the data organisation and analysis was the vast amount of data generated. The amount of transcribed data collected for collation was massive. It was not much of a surprise to the researcher because this is consistent with qualitative research, in general, and interpretative phenomenological research, in particular. The researcher had the option to use electronic software or to manually code the data. The latter option was adopted. The number of participants, fifteen (n-15), made it possible to manage. The researcher was mindful of the research objectives and questions and directed focus on these, while making sense of the nurses' dataset.

7.10 Mapping reflective interpretations of composite (group) superordinate themes

The nurses' composite superordinate thematic analysis, therefore, represents both the individual and the collective findings from all fifteen West African nurses. This research explored the expectations of West African migrant nurses and examined how cultural conceptions might explain their perceptions of experiences at work. It also considered how the nurses managed conflicts between expectations and experiences and ways of coping with their experiences at work. Smith, Flowers, and Larkin (2009) maintain there is no prescriptive way of analysing and presenting findings using the IPA; however, the themes of findings in the present research were organised in relation to the research questions.

“As the new clustering of themes emerge, check back to the transcript to make sure the connections work for the primary source material—what the person actually said. This form of analysis involves a close interaction between you (researcher-sic) and the text, attempting to understand what the person is saying but as part of the process, drawing on your own interpretative resources” (Smith, Jarman and Osborn, 1999:223).

The researcher used electronic highlighters in associating keywords and phrases from other nurses' accounts. While the first nurse's interview transcript was used to identify initial descriptive themes, the researcher looked out to identify new ones that arise while analysing each of the remaining fourteen nurses' interview accounts. This was to ensure that final group descriptive themes were not just from the first interview. The generated descriptive themes were then clustered through a further deeper reflective interpretation to evolve the superordinate themes.

For the participants' keywords and sentences to be considered relevant to descriptive and superordinate themes, they need to be recurrent in at least 50 percent of the participants' accounts. In the present research, the nurses' keywords and sentences used in the generation of both descriptive and superordinate themes occurred in at least 67 percent of the participants. In presenting these findings, the researcher took note of possible accounts of significance from the nurses' accounts that may not have had a general mention across all nurses' accounts. (Smith, Jarman and Osborne, 1999; Watson, McKenna, Cowman and Keady, 2008) The researcher's iterative and reflective interpretations of the original data and clustering of the descriptive themes (Tables 8a1-8a6) produced six superordinate themes. The following section presents both the descriptive and superordinate themes.

Chapter 8 Study Two: Findings (RQs2 & 3)

In answer to research Questions Two and Three: *How might cultural conceptions explain West African migrant nurses' perceptions of experiences at work in the United Kingdom? How do West African migrant nurses manage conflicts between their expectations and experiences?*

The researcher closely examined the nurses' accounts of their experiences and observations of events at work. In the first step in the analysis of the data (process Stage 2 in IPA), the researcher identified keywords and phrases in the nurses' accounts of emotive events that might reflect their individual conceptions of what happened and why they found it notable or upsetting. The individual nurse's key words, phrases, and sentences as applicable to both descriptive and superordinate themes as identified are included in tables before the findings section. In the next step (process Stage 3 in IPA), descriptive themes were produced to categorise and label the conceptions so that it was possible to assess how characteristic they were of the sample.

In a further step (process stage 4 in IPA), the descriptive themes that were based on the margin notes as indicated in the IPA processes were collated and clustered into superordinate themes that might explain cultural norms about the nurses' perceptions of appropriate behaviour contexts in work and social life contexts. The analysis generated six themes covering the research questions and generated insights to meet the aims and objectives of the research. The six themes identified were: power and leadership, lacking family life at work, caution in the management of conflicts, process defect and trust issues, well-being and organisational commitment, and positive reframing. Tables (8.1a-8.6a) below show the individual nurse's key words, phrases and descriptive themes emerging into the six superordinate themes.

8.1 Superordinate Theme One: Power and leadership

Tables 8.1 and 8.1a show the individual nurse's keyword and phrases and descriptive themes respectively that were clustered into the superordinate theme of "power and leadership."

Table 8.1 Individual nurse's quotes on power and leadership

WafMNs keywords, phrases and sentences relating to power and leadership	
Keywords/Statements **	Reflective descriptive themes
<p> " matters at work decisively" (Irene) "person to deal with issues" "reported to the manager" (Peace) "passing instructions" (Amie) "giggling during my handover"(Peace) "much more open" (Mary) "young white carer" (Mam) "manage the home properly" "supposed to use power" "I can be their mother or big sister"(Mam) "who are even younger" (Mary) "in my age when you compare it" "and pass information to you" (Joyce) "no one tells me"(Joke) "no one tells me what is happening" (Joke) "not being recognised" "with a left hand" (Tunde) "any elderly person" (Bash) "even respect my age" (Azeez) "have taken permission from me" (Tina) "after all she is the manager" (Adama) "did not listen to me" (Bose) "instead of accepting mistakes" (Bose) "the carers know more" (Bash) "no one cares to tell me"(Adama) "a carer refused"(Bose) "nothing is open"(Joyce) "a very minor mistake"(Amie) "take credit alone"(Mary) "struggling on my own"(Adama) "everything from the manager" (Adama) </p> <p> ** The textual context for each nurse's keyword/statement is provided in the quotes below tables 8.1 and 8.1a </p>	<p>Beliefs about:</p> <ul style="list-style-type: none"> • manager-subordinate power relations • age-related values at work • organisational lines of authority • managing organisational processes

Table 8.1a Clustering of descriptive themes into superordinate theme “power and leadership”

Descriptive themes	Superordinate theme
<ul style="list-style-type: none"> • manager-subordinate power relations • age-related values at work • organisational lines of authority • managing organisational processes 	Power and leadership

The four descriptive themes relating to the nurses’ superordinate theme on beliefs about power and leadership (Table 8.1) are described and explained in turn below with reference to the nurses’ relevant interview quotes.

8.1.1 Descriptive theme ‘manager-subordinate power relations’

Many of the participants expressed concern about what they feel is the delayed social relationship between the manager and the white carers in their workplaces. The nurses reported their frustrations that, with such informal relationships, management of their nursing homes becomes difficult. The following accounts from Irene, Mam and Mary express their concerns about these relationships.

*“The manager is supposed to be **the person that has authority so that she/he can deal with all matters at work decisively**, but where the manager socialises quite very easily with junior subordinates and colleagues it becomes difficult for the **person to deal with issues** when they arise especially when it involves those her social white carer friends” (Irene.)*

*“The manager is always with the carers, what they are doing or saying you, no one knows. If someone who is supposed to be on top is always chatting with the carers, sometimes on things not related to work, how can it be easy to **manage the home properly?**” (Mam).*

*“.... the communication between the manager and the carers are **much more open** than my communication with the manager, even as a nurse” (Mary).*

The nurses' accounts suggest deep worries about what they perceive as an ideal, a formal organisation structured to carry out specific goals and objectives.

Many of the nurses reported idle sessions between the managers and the carers that could be better used for work. In the following quotes, Peace and Amie expressed disappointment with the carers' attitudes even in the presence of their managers.

*"There was a time some white carers who work during the day reported to the manager about something that they said were not done properly at night, but the manager did not ask me about it but it was almost the talk on everyone's mouth. These carers are also very arrogant during my handover sometimes, they will be **giggling during my handover** in the morning. Sometimes, you think that what you are saying does not make meaning to them. They will be distracting others while I am talking during handovers" (Peace).*

*"I don't know whether they feel that I don't know what I am saying or maybe they feel I am **passing instructions to them**. But they should listen to me because I led the shift. They have no knowledge of nursing... But my problem is that the manager sometimes will be there and will not stop them" (Amie).*

The findings suggest deeper concern that close interaction and familiarity with subordinates undermines management assertiveness in the workplace and could have an impact on discipline at work and effective management control. These suggest the nurses' feelings that their managers informal relationships with the carers subverted the workplace power and authority structure which allow the carers to make unwarranted challenges to the nurses even in the presence of the managers.

The nurses' responses suggest their disappointment in relation to their expectations of an organisational environment of managerial assertiveness and control over matters. They argued that their managers' lack of control, because of authority and leadership breakdown, would make managerial oversight difficult and lead to work not being effectively monitored or allocated equitably. The participants' data suggest the nurses' feelings that managers' involvement with the white carers creates nonresponsive and disrespectful environments that cripple the manager in executing functions appropriately. The findings also suggest feelings of disappointment with their perceptions of the manager's involvement in matters with the carers

instead of matters which were relevant to the nurses' work. The nurses recollected and became sentient of their own positions and relevance in the power and authority dynamics in their workplaces. These feelings resonated across many of the other nurses, who felt that the authority of their manager was being compromised because of the carers' closeness with the managers. These findings suggest the nurses' feelings about their managers' inability to recognise and utilise their power and authority positions, which could affect the whole working of their organisation. The nurses' interviews, as in the following quotes from Mam and Mary, suggest their concerns that the managers' close relationships with the carers impact their own authority as nurses-in-charge.

*"We work like donkeys and some people will not do nights or weekends. The manager cannot even **use her position to** treat people equally. The manager is **supposed to use power** so that everyone will be treated equally The carers can always tell her what they want like changing their rotas, but I cannot"* (Mam).

*"... sometimes I feel that the 'white' carers who are even younger than me **make decisions for my manager** because they will not do their jobs and will expect me to do not only my job but also theirs as well and the manager encourages them because maybe because they are from the same country or they see me as being 'here for the money' ... the communication between the manager and the carers are much more open than my communication with the manager even as a nurse. You can understand why sometimes I do not trust how things are done because I do the work meant for **my juniors at work** and the manager don't even care"* (Mary).

The nurses' data suggest concerns about the impact that perceived familiarity between their managers and the carers could have on the whole organisational dynamics. They further suggest that the gaps they see in their own relationships with the managers manifest in outcomes that could be negative because they are not able to access favours and other resources as may be applicable. The following quotes, Adama and Bash showed their feelings of lack of involvement at work.

*"Some of these team leaders are mostly whites, now feel that nurses cannot **tell them what to do(...)** because they think they know **everything from the manager**. The manager does not do anything about some of their behaviours anyway. So, it is annoying sometimes....."* (Adama),

*“It feels sometimes that one is left on his own, the manager finds it much easier to be with the white carer’s discussing even what you, as a nurse should be discussing with the manager. In many cases, the **carers know more about** what is happening in the home than you, the nurse” (Bash).*

In the context of Adama and Bash’s perceptions, their expectations were that authority should be felt to be flowing from the power base of their managers to reassure them. The nurses’ accounts suggest fears of being outside the appropriate spheres of organisational networking, with many of them feeling that the socialisation dynamics leave them as “outsiders”. The nurses report their uncomfortable and unsettling feelings as their managers continue to engage more with their junior carers than with themselves, during their constant friendly, smoking breaks. In the following interview extracts, Adama explains her disappointment and feelings of being unrecognised, when it seemed nobody sought her permission, as nurse-in-charge, to go for a smoking break.

*“I feel bad about this, though, because our conversations are only about few minutes as if she is in a hurry for it to end but she relates very well with the other staff because they go out to smoke together at any time. Even when the manager takes any of the carers to smoke, **no one cares to tell me** that they are going out ... and I will be **struggling on my own** till they come in at their own time ... Well, I do not smoke, so I do not join them. I know she is not supposed to be down to earth with me, **after all, she is the manager**, but she is free with others, why not me too” (Adama).*

The data suggest that with perceived constant and friendly informal relations and interactions between their managers and their junior carer colleagues, the nurses feel undermined in the process of performing their own duties. There were also feelings of work overload which tasks on the nurses’ resources and emotions at work. The nurses’ accounts suggest a perception of the possibility that such socialising jeopardises interest-free management, allowing bias and discrimination to creep into management decisions. The nurses’ expectations of being accorded respect and recognition appropriate to their positions as nurses in-charge seemed lost due to their perception that managers interacted more with the white carers.

The data also suggests that the migrant nurses fear that the informal and close relationship between the white carers and the managers affects their own development of relationships with

their managers. This suggests their inclination to look to superiors for protection and advancement of their own causes within the framework of power and authority differentials between the superior and subordinates. In their view, the nurses felt that this type of closeness with the carers contributed to their managers not being able to treat the nurses' complaints against instances of perceived acts of insubordination as duly as expected. In the following quotes from Bose and Adama, the nurses expressed their disappointment about how their managers manage and recognise issues affecting them at work .

*“At a point, I was almost giving up when **a carer refuse** to do simple things, I asked her to do but instead went to the manager and lied against me. The manager was sarcastic and made me feel, I was harsh on the carer when I responded to the manager about the carer's behaviour towards me. The manager **did not listen to me** instead made me feel I am aggressive”(Bose).*

*“Some of these team leaders are mostly whites now feel that nurses cannot tell them what to do(...)The manager does not do anything about some of their behaviours anyway. So, it is annoying sometimes. Even when some visitors come to visit, the manager **will ask the team leader** who is around that time to take them round even when I am around. When they come to my unit, I will just be looking at them ... (Adama).*

The nurses accounts suggest that in their expectations, as nurses-in-charge, they felt that their managers' closeness with the carers affected how their own authority is recognised when carrying out their supervisory responsibilities at work. The nurses feel that there should be a clear distinction between the manager and the carers which, by extension, would encourage the carers to appreciate the nurses' roles as nurses-in-charge. Bose's concerns suggest feelings of disappointment that her side of the story about an issue with her subordinate was not considered. Bose therefore perceived the manager's defence of the carer as a reflective outcome of her familiarity with the carers which jeopardises the practice of interest-free management by her manager.

8.1.2 Descriptive theme ‘organisational lines of authority’

Many of the nurses reported their feelings of being side-lined in processes that require their leadership. Many also referred to instances when the relationship between their managers and carers had distorted the organisation's chain of command. Further to the feelings of

marginalisation, Joyce and Joke in the following quotes expressed how the lines of authority at work between them and the carers are not recognised at work.

*“ ... what I mean is that sometimes she (manager) will tell other staff to come and **pass information to you** and I feel not so good when people come across to me and tell me about this as if they are giving me instructions. In my anger, sometimes, I will neglect the information because I feel the manager knows how to reach me directly instead of using my juniors to pass the information to me.” (Joyce).*

*“The manager spoke to me few times and would not speak to from then on without a white carer being around. I said hmmm ... maybe it will change, but my brother, it has continued to be like that even up to today that I am speaking to you ... how many years now. On several occasions, the manager **bypasses me** to ask the white carers about issues that happened during my shift and I feel humiliated and/or not being recognised ... ” (Joke).*

The nurses' accounts suggest their frustrations with the manager's negation of the appropriate supervisory processes at work and non-appreciation of the workings of power and authority. Many of the nurses reported that their managers do not deal directly with them and sometimes would rather pass instructions to them through their subordinate carer colleagues. As a result of these perceptions, both Joyce and Joke sensed that their own authority and respect were being side-lined. The nurses' accounts further suggest that the nurses' view of communication processes in their organisations were contrary to their expectations about the normal organisational chain of command and consequently they felt that what should represent an ideal process of communication through the ranks were being eroded. In the circumstance, the nurses feel confused about what direction organisational communications should flow, thus creating unsettling environments with the nurses not sure of what follows next for them. The lateral communications channels, which seem to be adopted by some of their managers, make them feel that they are under the authority of both their managers and their junior carer colleagues.

Many of the nurses reported that they were not given responsibilities in the absence of the managers. The carers were perceived to allocate responsibilities to themselves without reference to the nurses as persons in charge and would not take instructions from the nurses. With information not available to them in some cases, the nurses felt handicapped in exercising their roles as nurses-in-charge. The nurses' perceptions, revealed in the data, suggest their

feeling that, in the absence of the manager, information and directives at work should be directed through them in the line of organisational chain of command. The nurses felt that any process contrary to this would mean a deliberate and calculated attempt to undermine their positions.

The nurses' accounts suggest their expectations of fostering relationships with identified key members of the organisation, in this case, the managers. However, the nurses' accounts suggest that they were not feeling a sense of belonging and engagement and that feedback mechanisms were not being applied appropriately and through the right channels. Many of the nurses reported that they do not get comments directly from their managers on what they have done, failed to do, or were expected to do. The nurses' current feelings reflect gaps between the nurses and managers, which tend to add pressure to trust issues.

The nurses' data suggest that, in the absence of a relational exchange between them and the manager through the formal process of communication, their feelings of inclusion in the affairs of running the home are compromised. The reports also suggest that the nurses' sense of being recognised and having their managers' support can only be appreciated through direct communication with them and not being routed through the subordinate carer colleagues. In which case, their managers avoiding contact with them and dealing with them through the carers represents a deliberate attempt to isolate them from mainstream organisational issues.

The nurses' perception of the absence of formal contacts and consultations with their managers on issues and matters at work, causes them to question the nature of their exchange relationship with the managers. The nurses' accounts suggest their disappointment on the lack of effective communication between them and their managers. Many of the nurses commented on their inability to reach out to their managers due to perceived lack of bridges in communication. They felt the situation, as the nurses' data suggest, was made more difficult by their carer colleagues occupying their time with the managers without the nurses having opportunities to reach out to the managers. In their view, this reinforced the managers' inability to maintain the right relationship between the manager and nurse subordinates.

The nurses' feelings suggest their fears that, without a strong and influential use of authority, their managers would not have the grounds to address the nurses' issues of concern without being biased towards the carers' opinions. These feelings possibly reflect the nurses'

expectations and wish for the experience that their managers create not only an organisational environment of strong and firm authority but also one that operates from a paternalistic framework of manager protection from which the nurses can draw strength as the nurses-in-charge.

The following quotes, Adama and Bash showed their feelings of lack of effective organisational socialisation.

*“Some of these team leaders who are mostly whites, now feel that nurses cannot **tell them what to do**. The manager does not do anything about some of their behaviours anyway. So, it is annoying sometimes. Even when some visitors come to visit, the manager will ask the team leader who is around that time to take them round even when I am around. When they come to my unit, I will just be looking at them ...” (Adama),*

*“It feels sometimes that one is left on his own, the manager finds it much easier to be with the white carer’s discussing even what you should be discussing with the manager. In many cases, the **carers know more about** what is happening in the home that you, the nurse” (Bash).*

In the context of Bash and Adama’s perceptions, their expectations were that authority should be flowing from the power base of their managers to reassure them. This suggests their inclination to superiors for protections and advancement of their own causes within the framework of power and authority differentials between the superior and the subordinates.

On the contrary, however, the nurses’ responses suggest their loss of confidence due to their perceived managers’ seeming loss of grip on power and authority and not being accorded respect by the carers. The nurses’ concerns suggest feelings of disappointment that the managers do not keep away from subordinate colleagues as this runs against their basic expectations of manager /subordinate relations. Subsequently, their expectations of advancing their positions as supervisors at work from the managers’ power base seem lost because the manager-carer relationship does not provide a conducive environment in terms of the exercise of authority so that the carers can understand the chain of command to show them respect.

8.1.3 Descriptive theme ‘age-related values at work’

Many of the nurses report their concerns about non-recognition of their age-related social values at work, which they expect to accord them corresponding statuses of relative control and command of respect. Mam and Mary, in their interview responses below, explain their displeasure that the young carers and even their managers do not recognise their ages to accord them the respect that is due to older colleagues at work.

*“When it comes to respect, I am sure I am older than both my manager and all the carers working with me. But the way they treat you (possible reference to herself) you cannot even think they know that **I can be their mother or big sister**. If they understand that, at least, they will say let’s respect her. There was a time, a **young white carer** came into the kitchen and I was there with another one who was not talking to me. But when the other one came in if you see what she said and did, hmmm, you will be surprised. First, she did not even greet, she start saying in a sarcastic way that it is like people are ‘nicking’ biscuits from the kitchen and looked at the other and both of them started laughing and went outside.....I don’t even like biscuits but they will think because we are from developing countries, we will be taken items from the home ... very disrespectful” (Mam).*

*“.... Sometimes I feel that the ‘white’ carers **who are even younger** than me make decisions for my manager because they will not do their jobs and will expect me to do not only my job but also theirs as well and the managers encourages them because, maybe because they are from the same country or they see me as being here for the money ... it is not right at all. The carers will even expect me, **in my age when you compare it** to their own, to do more lifting than them. They will be avoiding the dirty and heavy tasks for me to do ... I do not trust how things are done because I do the work meant for my juniors at work and the manager don’t even care” (Mary).*

The participants’ responses suggest the nurses’ beliefs that generational gaps should be accorded respect, and place them in a position of authority, were not being recognised by either the manager or their young white carers. From these findings, the nurses perceived an association of age with systematic authority and power relations.

The findings suggest a sense of deep-rooted perceptions of the social value of age even at the workplace, which was perceived to relate to seniority, wisdom, and respect within the workplace, but this seemed non-existent in their present work context. Tunde, in the part of his interview response below, reported his concerns about what he associated with disrespectful behaviour from a young carer colleague.

*“ ... Brother, you need to experience it to feel it. If a girl passes documents or any stuff for that matter to you with a left hand, in my tradition and culture, it is very **insulting and disrespectful**. There is this girl, she is in the laundry, any time she wants to pass anything to me, she would use her left hand without even any eye contact. Sometimes, these things would drop off because my hand had not reached before she releases it. She does not show any apologies” (Tunde).*

Tunde's, like many of the other nurses' perceptions of age-related values at work, suggest a schema which they seem to cherish, that appreciation of age would restore harmony at work. These assumptions from the nurses suggest their beliefs that societal and family values should be recognised in the workplace. The following interview extracts from Jenny and Bash and Azeez also revealed their feelings that the carers and sometimes managers whom they consider younger have no considerations for their age and the wisdom and experience that come with it:

*“Sometimes, some carers who by far are **my junior in age** find it difficult to take my instructions to do something and they will go to the manager to ask her what she wants them to do” (Jenny,)*

*“In fact, **any elderly person** that can give you instructions, you have to use those words of Sir or Madam for them. This is one thing that surprised me because everybody calls **each other by their names**. It is rude to call your senior even in your family by his or her name ... Ah, no, you cannot do that, even as I talk to you now, I am imagining when I get back home and my younger brothers and sisters calling me by name” (Bash).*

*“That girl can be **as young as my daughter** and cannot even respect my age and yet has the strength (sic) to report me to the manager. The manager is the same with them, isn't it” (Azeez).*

The nurses' accounts suggest their conscious sensitivities about the misunderstanding of these social values at their workplaces. These perceptions also highlighted the nurses' association of how social values should persist in organisations. The nurses' perceptions of expectations about

co-worker support and perceived supervisor support can be related to their beliefs that their sense of respect for their ages is appreciated, non-recognition of which would probably impact their emotional dispositions at work.

8.1.4 Descriptive theme ‘managing organisational processes’

Most of the nurses reported being left in the dark in relation to organisational information. Many of the participants described events, actions and behaviours that left them feeling anxious that the organisational processes seem flawed. Joke and Joyce, in the following interview extracts, express doubts on the transparency of the organisational process.

*“Sometimes **no one tells me what is happening**, even if it concerns me. It’s all about gossiping. If anything happens or you do something, no one even the manager cannot even discuss with you. We are human beings; we can make mistakes and even the manager makes mistakes ... I know it but I cannot say it but if I make mistake, the manager will not tell me but every other person will know about it” (Joke).*

*If you see them (a reference to her manager and white carer colleagues) together, know they are gossiping about somebody. Sometimes I just ignore them because if you join them, the next thing you hear is that you said this and that ... but they will not say what they said themselves. **Nothing is open**, maybe because they don’t want you to know what they know. I do not ask them, if they want to tell, they tell me. Sometimes, they will arrange on what they want to do but you won’t know about it” (Joyce).*

Joke’s concerns about the process, as the findings suggest, was evident in the nurses’ perceptions that informal flows of information, like gossip, could damage the way they were perceived by colleagues. The nurses felt doubts about organisational processes as a result of the perceived lack of formal relationships and clear lines of communication. This was evident from the nurses’ perceptions that information that should flow through a normal feedback processes, in this case, direct from their managers to them got mixed up because of the use of junior staff as intermediary. In the following case, the lack of formal communication channels led to a mistake that was blamed on the nurse.

“There was an incident where we have to admit an elderly resident. He needed this oxygen facilities and this was supposed to have been included in the pre-assessment ... but because

*the manager used a white carer who she just promoted as team leader to manage the admission this was not included ... **instead of accepting mistakes** she and the carer (her team leader) made, she was putting me under pressure of I should have known. How would I have known?" (Bose)*

Amie, in the following interview response, resonated similar sentiments to many of the other nurses that they have doubts about the processes at work, concerning reward and feedback.

*"When white staff do mistakes, it will be normal, but when you do a simple one, the whole people will be talking about it. Many times, I have seen a white carer make mistakes, and the manager will be like....emm, don't worry, darling, you know what you are doing, don't you, and will let go ...hmmm, but when a black staff does even **a very minor mistake**, the whole home will be talking about. Do you know, sometimes, you will be surprised to hear a resident ask you about the issues when you go into their room to support them ..."* (Amie).

*"People here want to **take credit alone** sometimes even when you are part of that success. They won't mention your name... There are times when I have shown a white team leader how to manage something and when the relatives came, the manager said it was the team leader who did it well. Instead of the team leader at least saying something on the role I played, she was only smiling, and I stood there disappointed and upset"* (Mary).

The above findings suggest that, in the expectations of the nurses, in situations where the management does not adopt firm and transparent processes in managing daily operational issues, this could lead to institutionalisation of the blame culture, where no one accepts responsibilities. This also suggests the nurses' adoption of and reliance on the organisational structures that they feel ensure that tasks are streamlined with responsibilities attached. If that is the case, the nurses feel safe and secure to carry out their duties and to be answerable on what they have been assigned to do.

8.1.5 Generation of the superordinate theme ‘power and leadership’

The descriptive themes as listed above suggest the importance of the nurses’ attachment of values to the bases and positions of power and how their managers appropriate these in their organisations.

The researcher’s deeper construction of the nurses’ responses suggests they believed a sense of familiarity between their managers and their white carer subordinates contributed to a disrespectful organisational environment. In view of this perception of informal and constant close familiarity between their managers and the white carers, the nurses became sentient of their own weaker position and relevance in the power and dynamics in their workplaces. The nurses’ consciousness about their managers’ use of power revealed their perception that the lack of a normal flow of communication within the right chain could lead to staff shirking responsibility or being unable or reluctant to accept responsibility.

The nurses’ perception that their managers do not relate to them appropriately was considered a relational issue that affects their relationship with other colleagues, especially the white carers. In that case, “we” versus “them” relationships are created, which places the nurses at a disadvantage. This would impact the nurses’ further perceptions of a lack of transparent organisational management processes within an open organisational framework. In the nurses’ beliefs, effective management involves equity applications in decisions, resource allocations and patronage. However, under the circumstances, both sides are oblivious of these differences, hence the problems in both communication and interactions. West African nurses in their interactions and behaviours expected clearer lines of authority and supervision.

In their beliefs and expectations, this would guarantee trust in the organisational justice system through fairness and equal distribution of opportunities. The strength of the nurses’ beliefs can be explained by how they are grounded in their cultural backgrounds in West Africa. Perceptions about the clear authority of the manager conform with the sense of protection. In their beliefs, the nurses consider it more reassuring that their managers assume the quasi-patriarchal roles of the males consistent within families back in their home countries. In this way, having their managers taking dominant but guardian roles in decision making gives the nurse a sense of protection and rationality in their choices. This was expected to also guarantee them predictable platforms on which to anchor their trust.

8.2 Superordinate theme two: Family life at work

Tables 8.2 and 8.2a below show the individual nurses quotes and descriptive themes respectively and how these were clustered into the superordinate theme of “family life at work.”

Table 8.2 Individual nurses’ quotes “family life at work”

WafMNs Interview keywords, phrases and sentences relating to Family life at work	
Keywords/Statements **	Reflective descriptive themes
“I was not myself” (Joke) “not bonding” (Tunde) “hostile and difficult” (Adama) “It makes me feel bad” (Peace) “are not the way we do”(Jenny) “emotional person” (Irene) “personal issues” (Amie) “like a second home” (Mam). “waving and smiling” (Bose) “hardly chat” (Ronke) “culture not to relate” (Tina) “meeting to greet” (Ronke) “family is important”(Azeez) “has taken sides” (Bose) “manager fails me” (Adama) “genuine smiles” (Amie) “take credit” (Adama) “role I played” (Mary) “no one finds it funny” (Joyce) “not even your friend” (Mam)” “we work as sisters” (Mary) “you still need the support” (Mam) “she asks about our family” (Amie) “even sit with you” (Bash) “you are not wanted” (Tunde) “in the morning” (Peace) “my family members” (Joyce) “people distant themselves” (Mary) “share greetings” (Adama) “show some concern” (Joke) ** The textual context for each nurses’ keyword/statement is provided in the quotes in the findings below table 8.2 and 8.2a.	Beliefs on: <ul style="list-style-type: none"> • communal bonding and family relations • team membership and interpersonal relationship • organisation/supervisor support

Table 8.2a Clustering of descriptive concepts into superordinate theme “family life at work”

Reflective descriptive themes	Superordinate theme
<ul style="list-style-type: none"> • communal bonding and family relation • team membership and interpersonal relationship • organisational/supervisor support 	family life at work

The three descriptive themes relating to the nurses’ superordinate theme on family life at work are described and explained in turn below with reference to relevant data.

8.2.1 Descriptive theme ‘communal bonding and family relations’

Most of the nurses revealed that their expectations about the type of relationship they had hoped to engage with at the workplaces were not reciprocated. Joke and Peace, in the following interview extracts, report their reservations that, in the event of personal family matters, they could not receive the adequate support they had hoped from their managers and colleagues.

*“When I received the news that my first daughter had a car crash back home which left her partially paralyzed, **I was not myself** and I lost it you know when I called my manager to inform her, she did **show some concern at first** but after that, no one among the staff further made any mention of it, except that I have to discuss my ‘time off’ to travel home. Even when I went back to work, **few people asked me** about it. I have come to know that the way people take things here are not the way we do in my country ”(Joke).*

*“**It makes me feel bad.** In my place, the family comes first and if anybody is interested in your welfare, the person would like to know about your family and children but here there is a very **deep distance** between me and manager” (Peace).*

In the first instance of reflective interpretation, the findings suggest that the nurses hope to have support to manage family life issues at work. These revealed the nurses' conscious sense of engagement in evaluating actions and considerations regarding collaborative relationships on aspects of their family well-being and pastoral needs. These feelings demonstrated the nurses' values regarding family issues and their sensitivities to these and considerations of their workplace as an extension of their families. The nurses' data suggest the deep feelings they had about their expectations of manager and co-worker socio-emotional support in relation to family and family related issues.

Many of the nurses reported feelings of being considered outsiders at work, with a sense of non-inclusivity and a lack of response to their personal needs. The nurses revealed their feelings of lack of empathy from their colleagues and managers with their circumstances, given that they are migrants who left their original homes to reside in an entirely different new environment. Irene, Amie, Mam and Bose expressed their sentiments in the following interview extracts that their treatment at their workplaces was like the treatment of strangers who were only needed as and when required for the purpose of the jobs.

*"Yes, I am a very **emotional person**. I think people should treat others like humans but No. At some time, I began to feel that these people (manager and colleagues), hmm, they **don't care, oh**. If you come to work, you are on your own, no one cares about what **you are going through** or how you feel" (Irene).*

*"The people look at the black nurses as we are only here for the money, it is difficult to see who asks you about **your personal issues**. It is not the same, my brother. If even they hear something about you, it will be a subject of general discussion and when they see you, they do as if nothing happened" (Amie).*

*"When at work back home, it's **like a second home** because you greet, share and hug people and it continues like that throughout the day but here No!. It's like is a crime to even want to greet the person because sometimes they simply walk away from you without saying a word to you" (Mam).*

*"....there was a day, I was walking in the high street, and I saw one of my colleague and I was **waving and smiling**, wishing to meet and talk, but she behaved as if I was a total stranger*

*and looked as if to say, why is she looking at me or smiling?... very, very strange!! If you depend on some people to give you hope, you **will be disappointed**" (Bose).*

The findings revealed the emotional outcomes in terms of mood and work behaviour that could result from losing out on expected social attachments at work. In their interview accounts, the nurses' perceived the actions and behaviours of both their managers and other white colleagues as being non-receptive toward them. These findings suggest that the nurses have strong feelings and expectations of socio-emotional support not only from their managers but also from their colleagues at work. Consequent to these expectations, there were distressed feelings and self-questions about social identity. Ronke, in the following response, illustrated her feelings of dismay that when she wished for and expected to engage in social experiences that could build up her social relationships, she observed differences in inclusivity. However, the main issues within the circumstances are that personal, supportive relationships seemed to be restricted to in-groups

*"I have another black nurse, though from Jamaica, that is working with us too. **We hardly chat together** because the manager will always **be against it** by making you feel uncomfortable. Themselves, they will be together chatting even in her office or when they are smoking, that is not a problem but when she sees two of us even just **meeting to greet**, she will be like, there is a job to do and no time to stand together" (Ronke).*

Most of the nurses' report that their managers and colleagues do not take an interest in them or what happens to their families because of a lack of a personal approach by their managers and colleagues. Tina's quotes below reveal her doubts on how relationships function in the workplace.

*"I don't have patience with some people that **don't care about others**, honestly. I decided to come to England because I feel they are very good. I know it is their **culture not to relate** much with people. But when I say people now, it's not true because they relate with each other among themselves. But to other people, No" (Tina).*

The findings suggest that the nurses felt a sense of betrayal of their expectations that the UK culture might be open and familiar. From their responses, the nurses felt that contrary to what they had expected, their managers and colleagues were socio-emotionally detached from them

and did not necessarily care about them beyond seeing the nurses as mere colleagues at work without any concern about their families. In the following interview quotes, Jenny, Joyce and Azeez reveal puzzlement and distress and present similar disappointment about personal relationships at work in comparison to what obtains in their home countries at work.

*“.... Because I come from a society where whatever ever you do is being watched by everyone. We also **care for each other** and when we achieve something, everybody takes care of one another, but surprisingly you don’t get that here easily” (Jenny).*

*“We have different ways of doing things both at home and at work. For instance, sometimes, we feel we are at home even when we are at work. We discuss our ceremonies and even contribute to help each other. Your colleague at work is like your brother or sister. If it is in my country, most people I work with will be known to **my family members**” (Joyce).*

*“I know in this country, at everybody in the families go their different ways and may sometimes not even see or bother about relatives...but my **family is important** to me. Also, maybe because here everybody has enough but in my place, we look after each other, you get? I feel sometimes that we misunderstand ourselves because of the way we see things” (Azeez).*

These findings represent one of the fundamental direct reflections of the nurses’ comparisons of their home country’s work experience vis-a-vis their current experiences at work. In response to feelings of lack of emotional considerations of their family and personal issues by their managers and colleagues, the findings suggest the nurses feel emotionally detached from work. These feelings suggest their apparent loss of sense of a desire for engagement to build socio-emotional relationships. Such feelings also reflect the nurses’ unconscious hold on their original cultural values relating to families and how they impact relationships in one’s place of work.

*“I have come to know that ways people take things here are **not the way we do**....even one of them came to me one day and said ... ‘Do you know that sometimes I do not know how to approach you or what to say to you’ but I said why, I am a human being like you” (Joyce).*

“If you meet a person and you did not share greetings, it is believed that both of you will be met with evil and bad thing will happen ... But here sometimes when I go to work and see some

people, they will either pass you or just pretend to be doing something till you pass. It looks very hostile and difficult environment sometimes” (Adama).

*“Even during break period, I stay on my own, I don’t like disturbing other people who chose to be on their own but we say hi sometimes but **that is not bonding**, is it?” (Tunde).*

In their perceptions, the nurses feel that the expected relational bonding with their managers and colleagues were absent at work. These perceptions were basically based on the nurses’ assumptions about values in their family life and work life with organisational members offering support through empathy and recognition of each other’s family-oriented needs. The nurses consider their workplaces as extensions of their families with colleagues and managers as members of that family. Therefore, any perception of a lack of empathy by managers and colleagues is interpreted as the indifference of one family member to another.

8.2.2 Descriptive theme ‘organisation/supervisor support’

Many of the nurses reported that their managers are not always there to play the advocacy role for them to reassure them. Bose and Adama, in the following quotes, expressed feelings of disappointment when they had expected the protection of their manager against what they perceived as unwarranted attacks and verbal outbursts from persons they considered as “outsiders”.

*“ ... On several occasions, the manager **has taken sides** with relatives of residents when it concerns issues with staff ... always protecting herself. But I am not a fool....Sometimes, I think that the manager feels it’s **all about herself**...hmmmm, you know wanting to be liked by the relatives, but she is also supposed to support your staff” (Bose).*

Bose’s account, as with many other nurses’ accounts, reveals that she feels left on her own during challenges at work for which she needed both organisational and managerial support. This and many of the other nurses’ interview accounts reflected the nurses’ expectations of their managers’ presence as a paternalistic image from which they draw their inspiration and strength. Bose felt that her manager should have intervened on her behalf in such circumstances.

*“ ... Some relatives are terrible ... there is a relative that never sees anything good I do whenever she is around. Always acting as if to say she wants to direct me on what and how to do things concerning the care of her father ... so instead of maybe giving me the support, the manager will want to please her by accepting her views against what I do and how I do them. There are areas where I feel the **manager fails me**. She will be like friendly sometimes but when you need her to be there for you, no she wants to be liked and you will be surprised how she will change ... ” (Adama).*

The findings suggest that the nurses expect their managers to present as “parental figures” to them. These findings indicate a natural sense of vulnerability for which some sense of protection was needed. The nurses expected effective attention to both their work issues and family matters. In circumstances where that does not happen, they feel disappointment and disillusionment. In the absence of their family members, the nurses strongly relied on the interactions and relationships they would garner at work to sustain them emotionally

The data suggest that the nurses, based on these expectations of their managers’ pastoral support, had divulged their intimate and personal matters to the managers. However, because of their experiences, the nurses’ expectations diminished as they faced the reality of individualistic tendencies at work. In the following interview quotes, Joyce, Ronke and Mary expressed their shock as they thought they were not getting what they expected in terms of closer rapport.

*“She hardly asks about how am coping but would rather start to ask me about what and what we have in my country, she sounds sarcastic sometimes, but I know that she wants to tease me but more seriously gets **her own satisfaction**” (Joyce).*

*“In my place, **we work as sisters** at work. When you are down, your co-worker will understand but not here. You are doing your own thing. So, you see, I wanted to see them as part of me, but it is not like that here” (Ronke).*

“I know we have different cultures, but we can get over all these with respect. Sometimes you wish that we work as sisters because of the way people behave to you” (Mary).

The participants’ data showed that they reacted sensitively to issues where they felt their managers and colleagues were not responding warmly to them. Most of the nurses felt that

they were welcomed initially at work but progressively the level of interactions between them, the managers and their carer colleagues was reduced. The extract below from Mam and Peace further related how perceptions of the manager's lack of empathy as well as acts considered non-receptive toward the nurses were interpreted

*“ ... You know we are human beings, no matter how strong you think you are, you still need the **support of the people** ... you go to the manager sometimes, she will feel that maybe you want to be told what to do, I have people say to me (gossip) that the manager sometimes closes her door so that people like me will not be disturbing her now and again. I don't go there for no reason, in Africa, the people you work with are like your familybut when the manager is **not even your friend**, where do you go?”(Mam)*

*I was thinking all is (sic) rosy mixing up with people ... none of them will **even sit with you**, they will all congregate in their own group ... I found out I was not included” (Peace).*

These findings showed the nurses' strong feelings that their organisational lives and socialisation patterns are basically linked to their relationships with their managers. For instance, the nurses' account identified greeting as an expected contribution toward their feelings and sense of belonging and acceptance within their work groups and organisations. The findings suggest that the nurses' perception of a supportive relationship with their managers would engage them more positively into the organisational lives. However, the data revealed the nurses' perception of their managers and colleagues lack of understanding of the nurses' paternalistic expectations. In the interview quote below, Amie recollected her and other nurses' previous experiences with a former manager of British descent whose interactions with the nurses demonstrated a more positive experience.

*“There is something I want to say which is that there was this lady, she is white, but she is a manager at the head office. She was such a great help and inspiration... We (foreign nurses) love this woman to bits. Whenever she visits our home, you are sure to get some **genuine smiles that day**... hmmm, very down to earth lady. At some point, we started calling her 'mama Africa' because of the way she makes you feel at home. We always wished she was the line manager. I was told that she used to work with an international organisation and used to travel all over*

*the world. I think she understands all of us very well. I miss that lady. She is retired now. If all the white managers are like her, I will say that **I can go to any length** to do anything. She was such a nice woman. She will tell you about her cruises, her holidays and all about her family. When **she asks about our family**, you will see it straight away that she was genuine. She will hug you, talk to you, smiles a lot....no she was nice” (Amie).*

The nurses related these positive experiences with the manager to their perception that the manager had travelled widely, hence her extensive appreciation of global diversity issues and in particular, understanding the nurses' interrelationship and paternalistic needs at work.

8.2.3 Descriptive theme ‘team membership and interpersonal relationship’

Participants reported problems in engaging appropriately at work. In the following interview quotes, Peace and Mary reported their observations and feelings of being deliberately ignored in and outside of work.

*“At first, I felt quite easy with the people. I was, like, at least I can easily bond with them. But later, there are sometime when I see any them at the town centres any other social environment, hmmm, the way **they will pass you**. There was a day, I felt very embarrassed because I saw two of my white colleagues in town, I was looking excited to share greetings... They did not respond. I felt ashamed of myself, other people were like looking at me” (Peace).*

*“I wanted to embrace the whole British society because I was thinking I had escaped from my worries at home ... But I feel lonelier now than ever ... it is difficult to embrace people here. I cannot even have a meaningful relationship ... I was thinking of starting a relationship here ... I am finding it difficult now to cope and handle it. People **distance themselves** from you and you are pushed to the wall, you stay on your own ... when you smile at some people, the response you get sometimes is very discouraging”(Mary).*

From their accounts, the nurses' perception of exclusion suggests disappointment with an initial expectation to be included within organisational and social circles. The findings suggest that the nurses' expectations of relationships that extend beyond the immediate work environment and be characterised by observable, relational, social exchange of greetings to show oneness and common social identity as they know it back in their home countries. The following quotes from Adama and Peace show how important greetings and acquaintances are to them.

*“ ... in my place when you see somebody whether you are related or not, you must share greetings, especially in the morning. We take it that the beginning of a new day carries with it various signs and omens. If you meet a person, especially first thing in the morning and you did not **share greetings**, it is believed that both of you will be met with evil and bad things will happen ... But here sometimes when I go to work and see some people, they will either pass you or just pretend to be doing something till you pass” (Adama).*

*“My problem is not that some of the people do not come to you for anything, but when these are the first people you see at work, the way they respond to you **in the morning** changes everything for you that day ... they will ignore you. You don't even know where to start for the day ... your day becomes negative from the beginning” (Peace).*

The findings equally revealed that apart from the nurses' schematic belief in the efficacy of an overt show of affection for social cohesion and acceptance, the nurses also placed supernatural significance on these norms and how they impact on their daily lives. The nurses' unconscious reference to these beliefs again suggests their continual adherence to cultural interpretations of events around them, even outside their countries. In the nurses' perceptions of the early morning interactions, there remains a strong spiritual significance. Therefore, not getting into the mindset for the day, through such mutual socialisation from greetings, was considered the antecedent for a negative mood and a bad omen and consequently lead to a bad day either at work or in subsequent social contacts and interactions.

The following extracts from Tunde, Tina, and Joyce showed how differences in their interpretation of expressions of humour as a means of organisational and social interactions make them feel at work. Social interactive tools and sentiments were interpreted and perceived in different ways so that instead of forging bonding, they became more of a divisive element.

*“I wanted to be a friendly person but if someone does not **want your cooperation**, there is nothing you can do about it. The same thing with my white colleagues. Sometimes I assume that they are always happy when I am moody. So sometimes when some of them come smiling over something, and if you don't join, they would say you are of a bad mind. I am not, only that sometimes when you **join in their jokes**, they make you feel like **you are not wanted**” (Tunde).*

*“ ... These people are **very sarcastic**, and they can insult you in different ways. **I do not like their jokes**, and these are on me every time ... yes, I mean they make me sick with their jokes all the time. They **can use words**, and you know immediately they are referring to you ... But I can't react because they will deny they did not call my name. And you know what, any little reaction from you, they will say you are **rude or aggressive**” (Tina).*

*We have different ways of doing things both at home and at work. For instance, sometimes, we feel we are at home even when we are at work. We discuss our ceremonies and even contribute to help each other. Your colleague at work is like your brother or sister. If it is in my country, most people I work with will be known to **my family members**. It is all about **being together** which now helps us to work as a team at workbut even when I share in jokes and funny stories, **no one finds it funny**, instead they will make you feel not intelligent enough for that joke ... it's not easy, my brother ... ” (Joyce).*

The responses and data suggest the nurses' high sensitivity to common social jokes and humours used by their colleagues at work. The findings suggest a lack of mutual understanding of humour and jokes that could advance socialisation processes and engagements. However, it was not clear whether the nurses' engagement with these humours and jokes were due to the use of peculiar jargon which made understanding difficult or the contents of the jokes and humours. Either way, the findings suggest that the nurses' perceptions of the use of such social interactive tools and sentiments were interpreted and perceived in different ways so that instead of forging bonding, they become more of divisive instruments .

8.2.4 Generation of the superordinate theme ‘family life at work’

The descriptive themes from the margin notes (keywords, phrases and sentences) of the participants suggest that the nurses expect interactions that should project their bonding in relation to care, concern and general socio-emotional support at work. The nurses' expectations of levels of care and concern consistent with feelings for family members suggest their attachment to feelings of community and family life.

The deeper reflective interpretations of the described themes in this cluster suggest that the nurses' have not shed their strong attachment to their original values of family life, community, and social life. However, it seems likely that the nurses managers and colleagues of British

descent, from whom they were expecting emotional commiserations are quite ignorant of the values they attached to some events and emotional relationships. For instance, for most of their work hours, activities that seemed to promote communal social interactions were predominantly held in the coffee room or smoking shelters. While these could have held a strong social attraction for the British managers and colleagues, West African migrant nurses are not culturally attuned to these symbols of social interactions.

In addition, the nurses expected greater bonding in terms of the manager and colleagues sharing more in terms of being responsive to their family-related affairs but, since some of these are considered personal issues, the nurses felt lonely and unsupported in the circumstances since this informed their expectations and their critical evaluation of their experiences at work. In the circumstances where these seem to exist, the activities do not conform to what the nurses are used to. The nurses perceive an absence of closer bonding and, by extension, a lack of organisational and management support to sustain their values of family life while at work. West African migrant nurses perceived a sense of isolation and loneliness that impacted on their sense of organisational identification and self-esteem.

Coming from a cultural background that encourages a communal sense of well-being and extension of family values to workplaces, the nurses' perceptions of aloofness on the part of their managers and colleagues represented an unwelcoming environment. However, an interesting find from the interview responses raised questions about the migrant nurses' perceptions of micromanagement and perceived organisational/supervisor support as represented in their managers' interest in how they carry out their tasks.

8.3 Superordinate theme three: “caution in management of conflicts”

The individual nurses’ quotes as presented in table 8.3 and the descriptive themes as presented in table 8.3a show how these were clustered to form the superordinate theme of “caution in management of conflicts.”

Table 8.3 Individual nurses’ quotes “caution in management of conflicts”

WafMNs Interview keywords, phrases and sentences relating to caution in management of conflicts	
Keywords/Statements **	Reflective descriptive themes
<p>“made any complain” (Joyce)</p> <p>“do all things alone” (Bose)</p> <p>“don’t have anybody to share” (Mam)</p> <p>“not a strong person” (Mary)</p> <p>“cleaning and doing the laundries”(Tunde)</p> <p>“do my own things” (Irene)</p> <p>“not used to that type of life” (Irene)”</p> <p>“it is like bringing myself up” (Irene)</p> <p>“use to die in silence” (Tunde)</p> <p>“make anybody to know” (Amie)</p> <p>“know I will not succeed” (Irene)</p> <p>“force myself to people” (Adama)</p> <p>“don’t like disturbing” (Mary)</p> <p>“but I can’t complain” (Mary)</p> <p>“cannot tell anybody” (Amie)</p> <p>“gone through a lot” (Amie)</p> <p>“ready to listen (Bash)</p> <p>“Worry them” (Bash)</p> <p>“bring problem” (Ronke)</p> <p>“will be giggling” (Jenny)</p> <p>“but I trust in God”(Ronke)</p> <p>“ routine is going to work” (Adama)</p> <p>“force myself on people” (Adama)</p> <p>“ avoid mistakes”(Adama)</p> <p>“leave them” (Bose)</p> <p>“difficult to understand” (Azeez)</p> <p>“worse for myself” (Bose)</p> <p>“annoy some people”(Azeez)</p> <p>“arrange on my own”(Ronke)</p> <p>“my manager knows what is going on”(Tina)</p> <p>“you don’t know what you are doing”(Irene)</p> <p>** The textual context for each keyword/statement is provided in the nurses’ quotes in the findings section of study 2.</p>	<p>Beliefs on:</p> <ul style="list-style-type: none"> • soft treading on concerns • rationalisation of choices

Table 8.3a Clustering of descriptive concepts into superordinate theme “caution in management of conflicts”

Reflective descriptive themes	Superordinate theme
<ul style="list-style-type: none"> • soft treading on concerns • rationalisation of choices 	Caution in management of conflicts

8.3.1 Descriptive theme ‘soft treading on concerns at work’

Most of the nurses reported processes and procedures that they feel concerned about but were careful about raising either with the persons involved or with their management. Some of the concerns, reported by the nurses, included experiences of task allocations that they felt increased their work pressures. In the following interview quotes, Joyce, Ronke, Bose, Tunde and Jenny express their concerns about their managers’ expectations of what tasks they need to do at work and their feelings that the managers treat others differently.

*“My manager also thinks sometimes that we (foreign nurses) should be doing the most difficult hours. There was a time, there was staff shortage for our night shifts. We have one white nurse who works with us. So, the manager made the rota so that every nurse will have a slot to work at least one night during that time. All of us foreign nurses were on the rota, except the English nurse. **No one made any complaints** because we heard was that she does not want to do night duties. Ok ... that one goes” (Joyce).*

*“I had a sensitive family issue, I requested for a day off, the manager told me that there was no cover. She said she does not want to bring in agency staff because of her budget. She said I must have to **arrange on my own** to swap with another willing colleague. She know this was not possible, she insisted I should cover my shift. She does not even any problem I have and cannot swap me on her own with the only English nurse. She said ... No ooh ... (using the nurse’s name) will not accept. She likes her weekend off. I was like you are the manager. She was supposed to use her authority ... **if you make complain** the manager will make it look you don’t like the nurse and **bring problem** between two of you” (Ronke).*

*“Sometimes I will be giving medication , the manager will also want me to finish quick and go and do laundry even when other people are idle talking. When I try to complain that I need to be careful and take my time on medication. She will see me as lazy. She wants you to **do all things alone**. When you talk about other people ,they will see it as you are attacking or reporting the person for nothing? It will then be a **problem between you** and the person. There was a time when one of the carers who is white did something and the manager was very angry at that, but when she found out who did it, she was like ‘oh, don’t worry, we all make mistakes. If it has been any other person, she will not see it that way” (Bose).*

*“The residents rooms need to be tidied but where we don’t have cleaners, the carers are expected to do both **cleaning and doing the laundries**. But on many occasions, these will not be done.... Instead of the manager getting the carers, she will call me to do them. She will say the carers are busy...but the carers are busy doing nothing...or you will see them pretend to be keeping one resident company for the whole day. The manager knows that the carers do not like doing manual tasks, but she avoids telling them off.” (Tunde).*

*“... they **will be giggling** during my handover in the morning, sometimes you think that what you are saying does not make any meaning to them ... **distracting others** while I am talking ... My friends who work during the day see a lot, oooh. I like doing nights now. **I am not a strong person** who can face tough times with people. It is all about seeing me as someone that cannot make decisions they could follow or rely on” (Jenny).*

The findings suggest not only the nurses’ perceptions of lack of fairness about the allocation of tasks and administration of disciplinary processes but also their strong feelings about these but lack of will to raise their voices to complain. These findings suggest the nurses’ assumptions that making a complaint would mean bringing themselves into an unhealthy spotlight which could evoke possible interpersonal conflicts they were not emotionally prepared to manage.

The data revealed the nurses’ reluctance to complain and also their acts of always attempting to play down a situation in order not to exacerbate it. In their perception, maintaining the status quo sustains them in terms of emotional stability and security of job security. The data suggest that the nurses, in adopting the position of not voicing their concerns, were perhaps considering

the natural strategy of adopting the least confrontational approach to resolve interpersonal organisational conflicts.

*“Sometimes when I am leading a shift, some of the white carers will go out in groups for cigarettes **without even informing me**. They do that with the manager whenever she is around. In cases like that, **I will not even disturb** them or answer their queries. **I do my own things** and when my shifts end, I carry my bag and leave Why, because, it is like **bringing myself up**. So that everybody would be talking about. I don’t believe it is the best option to take. **I am not used to that type of life** where everyone will be reporting any little thing that happens ... no, I don’t” (Peace).*

These findings suggest that the nurses’ judgment in not following up on any of their concerns was aimed to keep harmony in the organisation. Even where there were processes and procedures in place for the nurses to discuss and address issues concerning their perceptions and feelings, the findings suggest that the nurses would rather remain silent on those issues of concern. The responses suggest the nurses feel that it would not be in their best interest to make a fuss about concerns and apprehensions so as not to exacerbate the situation. The nurses’ perceptions were that raising concerns with their managers or following any formal process of mediation would perhaps lead to direct personal conflicts. In the circumstances, the nurses’ data suggest their feelings of being ill prepared to deal with interpersonal conflicts at work. The nurses feel they would be unable to face or cope with what they fear could be a direct confrontation.

The following extracts from Mam, Irene and Tunde illustrate the nurses’ self-assumed pacifist positions on issues of concern to them at work.

*“Even the relatives will sometimes come to give you instructions on what to do as if they know it better than you. They cannot do like that to even the white carers but maybe because I am black, and my colour makes it easy to address me anyhow they want. **I don’t complain** oh about these experiences, but it affects me more when you don’t have **anybody to share** with what you are going through” (Mam).*

*“My dear, honestly, I am OK doing night duties because you see less people and residents will be sleeping. You don’t see people that will think **you don’t know what you are doing** ... you*

do your night and go your way in the morning, no wahala ... Even when you do your best during your work, some people will only be looking what for what you did bad” (Irene).

*“ The was one day, I was almost crying when a relative came in to see her mum and she met me, she did not even greet, she just said, eemm, please my mother likes anyone who needs to feed her to wash hands properly.’ I was not expecting that, so I was shocked. She knows people wash hands, I was thinking, is it because I am black that is why she was making the statement. There is no way I can feed anyone with dirty hands. I went home that day and felt so bad. **I did not mention it** to my manager because I know. I will **not get a good response** from her. So, I **used to die in silence** and pressure. Maybe I should have reported it as **an act of bullying**” (Tunde).*

Since they did not use the grievance processes in their organisations, the data suggest that the nurses adopted a rather delimiting option of isolating themselves from the situations and/or persons who they feel cause such feelings and concerns to them. In some instances, the nurses varied their shifts to avoid involvement in day shift procedures that could lead to other people’s scrutiny and assessments of their activities. The finding revealed that the nurses were aware of the indicators of unfair practices and treatment but would rather avoid raising these as concerns. This finding reveals a possible consequence that the nurses may avoid reporting errors at work which could require immediate remedial measures as well enhance their learning. Tina felt she should not have to report problems because she felt her manager should be aware of them.

*“I cannot say that maybe I am right every time, but if the manager is concerned, I don’t have to go and report every time to her. White carers report nurses every time, but I cannot do that because I feel **my manager knows what is going on**. She sees my mood sometimes but, no she won’t ask me, so I know she can ask me how I feel about them” (Tina).*

The fact that the nurses chose to isolate themselves from threatening situations and persons suggests that they expected their managers to follow up on their silence to check what was making them present such isolation behaviours. It was, therefore, the nurses’ expectations that withdrawing and adopting non-voicing and quiet positions at fora such as in team meetings or other ways of making contributions on issues, would lead their managers to draw appropriate conclusions about their concerns at work. While this finding reinforces the suggestion that the

nurses deliberately adopted conflict avoidance approaches to pacify situations at work, it also revealed the nurses' expectations and reliance on their managers advocacy for them, with their assumptions that their circumstances must be obvious to their managers. In the following interview extract, Amie reported a process that denied her an opportunity for upward mobility at work and how she managed it.

*“There was a time, I think they were looking for some sort of a supervisor, and I came across an email my manager sent. I think somebody maybe mentioned my name to her as a possible option, but she replied that I am not assertive. The note was out of date by the time I saw it. Though she mentioned that I seem to be a good nurse. ... I did not make **anybody to know** this is what I saw. I was not **given that position** ... so from there ...” (Amie).*

While the nurses have in some cases responded that they were not keen on applying for or seeking higher responsibilities, Amie's case suggests the implications of the nurses not having access to organisational information and resources that could enhance career their development. The findings suggest that by not addressing the issues and opting to withdraw and isolate from the mainstream organisational socialisation processes, the nurses became further alienated from the organisational information, social support and networking that they need to drive their professional development. The findings also suggested that perceptions that the nurses were not assertive could stem from their choice of conflict resolution strategies. In the following quotes from Irene and Bash the nurses' express their issues of trust with the processes at work.

*“I have an issue with an administrator, who I know **should be under me**, but she decided to come and **intimidate me** as if she is my boss. She only does paperwork and does not know anything with nursing or healthcare but whenever the manager is not around, she wants to be the **manager over me** even when I am the nurse-in-charge....**she was always supported** but not me” (Irene).*

*“There was this carer who was obviously rude to me just because I asked her to do something which she was supposed to do. She did mention something under her breath **about my race** and further walked out on me. My manager did not do much to address the issue because they are the same as friends ... So even if I want to follow up the issue, who will be my support, my*

manager? I know **I will not succeed** even if I want to follow it up to the head office, they are the same, what they say inside, are you there” (Bash).

This also reflects the nurses’ perceptions of a lack of trust within the organisational processes.

8.3.2 Descriptive theme ‘rationalisation of choices’

Most of the nurses reported making deliberate choices to manage their concerns in a way that would be most convenient for them in the circumstances. Rather than raising concerns about problems with organisational processes, the nurses chose to guard against their involvement in organisational activities. The nurses reported avoiding situations at work in order not to be involved in any possible mistakes and managing the situations through limited involvement in organisational affairs, dealing only with the jobs assigned to them.

In the following extracts, both Adama and Azeez narrated their deliberate actions of not getting deeply involved in work affairs or making contributions that could be misunderstood amid the experiences they are facing.

*“My routine is going to work, face pressures there, come back home and repeat the routine next day. Because no one at work, not least the manager has ever seen the goodness in what I do, I feel very lonely at work sometimes. I **don’t force myself** on people. But no, because I try my best at work because I don’t want to make mistakes that can affect me one way or the other because I am still not a British citizen yet. So I do my best **to avoid mistakes**”*(Adama).

*“But when I speak to any of them, even my carers they find it also **difficult to understand me**. This makes me also not feeling confident to open up at discussions. They don’t treat me with empathy over this because it’s like **I annoy some people** when I say my views. I don’t talk much; it is good for me **not to be told off**”* (Azeez).

Most of the nurses reported that they were able to manage the situations through limited involvement in organisational affairs, dealing only with the jobs assigned to them. Tina, Ronke, Bash, Bose and Amie in their following interview revealed reasons why they feel the way they do.

*“Initially, I was trying to be open and friendly with everyone, but some people thought that I was being **noisy and irritating**, so I withdrew and since then, I was not making much contributions in the open. Even during break period, I stay on my own, I **don’t like disturbing** other people who chose to be on their own” (Tina).*

*“Sometimes, I ask myself, am I that bad that even in my role as a nurse. When I was in my country, I know my honour as a nurse, I use to work in the A&E (accident and emergency unit). My colleagues and even doctors used to say I am more than a doctor in the way I manage the work. Now when people here do not see any good in what I do, I cry sometimes that I am wasting here and people treat me as they like, **but I trust in God** because only God knows why I am here” (Ronke).*

*“She will think that I am complaining, please. You can only talk when people are **ready to listen to you** ... but you will know when people are ready to listen to you only when those people show interest in you, at least even if not all the time, at least sometimes. But no, you suffer things alone. In their culture, I think they don’t want you to **worry them** with your problems” (Bash).*

*“I am a young professional nurse, I know I am not the ‘madam know all’ but when it comes to nursing, it’s my calling but here, no one recognises me but **I can’t complain, I just leave them** and their wahala (feelings), you know. I don’t want to make things **worse for myself**” (Bose).*

*“I cry because I may be at work, but my mind is not there and if anyone pushes me that time, I will fall over like a piece of paper, I **cannot tell anybody**. When I come back to my house, I just shed tears. I am **going through** a lot at the moment ...” (Amie).*

The data suggest the nurses’ rationalisation into reasons and desires to relax their concerns. While the negative impact of the nurses’ adoption of the non-confrontational, pacifist approaches and self-withdrawal in managing their concerns at work were obvious to the nurses, they continued to maintain the status quo. The nurses’ perceptions of lack of support and trust issues make them feel that in engaging to address their concerns, they would be fighting and addressing their concerns from positions of weaknesses.

8.3.3 Generation of the superordinate theme ‘caution in management of conflicts’

While the nurses reported experiences of flawed organisational processes and incidents relating to the dysfunctional actions of both their managers and colleagues, they feel reluctant to voice their concerns and frustrations. The nurses’ responses suggest that, even though they experienced emotional and difficult situations and were concerned and disturbed as a result, they believe that it would not be in their best interest at work to report and make complaints. They were aware of processes both internal and external to the organisation to seek redress, but the findings suggest that the nurses would rather choose not to complain. The nurses’ rationalised that voicing concerns would lead to interpersonal conflicts at work that would isolate them much more than it would include them in the organisational processes, hence the nurses’ disposition to use caution at work with colleagues and managers. While this option was handy, the findings suggest that it worked more to the disadvantage of the nurses.

The nurses’ responses to their perceptions of concerns and interpersonal conflicts involved a non-voice, avoidance coping strategy. This not only alienated them from their circle of organisational networks but also limited their access to relevant organisational resources, including relevant information. A cultural analysis might explain the nurses’ adoption of the non-confrontational approach to conflicts at work as uncertainty avoidance cultural value that Hofstede associated with West Africa (Hofstede.1991). The findings highlighted the nurses’ perceptions of expectations that their managers ought to notice when they were unhappy or being treated unfairly. However, the findings revealed that issues of lack of trust rather than conflict avoidance might lead to apprehension about organisational processes and the wisdom of complaining about unfair work processes.

8.4 Study Two: Findings (RQ3)

In answer to Research Question 3: *How do West African migrant nurses manage conflicts between their expectations and experiences at work*, the researcher closely examined the nurses' accounts of their experiences in the context of their pre-migration expectations. In Study One, the nurses provided insights through their explanations of their reasons for migrating to the United Kingdom. The reasons suggested the nurses' subsequent expectations to include their aspirations for skills and knowledge improvement, aspirations for safe working environments, aspirations to achieve and sustain families economic and financial responsibilities and aspirations to enhance personal and family social statuses. Based on the above, the researcher examined the nurses' perceptions of their experiences at work. In the first step in the analysis of the data (process Stage 2 in IPA), the researcher identified keywords and phrases in the nurses' accounts of their daily interactions at work in the context of their expectations. In the next step (process Stage 3 in IPA), descriptive themes were produced to categorise and label the nurses' perceptions so that it was possible to assess how characteristic they were of the sample. In the third step (process Stage 4 in IPA), the descriptive themes were clustered into superordinate themes.

The superordinate themes clustered from the descriptive themes are outcomes of the nurses' daily encounters at work and how they impact their work behaviours as well as how they coped in the circumstances of expectations and experiences at work. The nurses' evaluations of their experiences produced outcomes and consequences in behaviours and coping. The outcomes and consequences identified in the descriptive themes and were clustered to produce three superordinate themes of 'process defect and trust issues', 'well-being and organisational commitment' and 'positive reframing'. Sections 8.4.1 to 8.4.6 presented analysis of the findings leading to the generation of the superordinate themes that are used to answer research question three.

8.4.1 Superordinate theme four: Process defect and trust issues

The individual nurses' perception quotes as presented in table 8.4 and the group descriptive themes as presented in table 8.4a were clustered into the superordinate theme of process defect and trust issues

Table 8.4 Individual nurses' quotes " process defect and trust issues"

WafMNs Interview keywords, phrases and sentences relating to process defect and trust issues	
Keywords/Statements **	Reflective descriptive themes
<p> "not organised ... nobody will help me (Peace) "most difficult jobs" (Jenny) "does not relate to me" (Joke) "no one will monitor" (Bose) "trust the manager" (Jenny) "about what you do wrong" (Amie) "will not even let you know" (Joyce) "continue to discuss you" (Joyce) "want to support" (Ronke) "always want to correct me" (Adama) "we don't hide things" (Tina) "trust people at work" (Ronke) "change their shifts" (Jenny) "in third-world countries" (Azeez) "make similar mistakes" (Azeez) "bring up ideas" (Ronke) "trust to tell my story" (Peace) "want to support me" (Mary) "do not show appreciation" (Mary) "doubting myself" (Mam) "I hardly say anything" (Adama) "how can you progress" (Ronke) "am always very careful" (Tunde) "a distance between us" (Tunde) "I do not want positions" (Irene) "I even fear for my pin" (Mam) "not looking to be manager" (Jenny) "she did not know" (Ronke) "will twist it." (Peace) ** The textual context for each individual nurses' keyword/statement is provided in the quotes in the findings below tables 8.4 and 8.4a . </p>	<ul style="list-style-type: none"> • feelings of betrayals • feelings of doubts and shock

Table 8.4a Clustering of descriptive themes into superordinate theme “processes defect and trusting relationships”

Reflective descriptive themes	Superordinate theme
<ul style="list-style-type: none"> • feelings of betrayals • feelings of doubts and shock 	Process defect and trust issues

The two descriptive themes are described below and explained with reference quotes for the individual nurses’ relevant data.

8.4.1.1 Descriptive theme ‘feelings of betrayals’

The evaluation of the nurses’ perceptions of their experiences at work reveal many of the nurses’ feelings of their managers and colleagues not engaging well with them. In the following interview quotes, Ronke and Peace expressed their feelings of disappointment and betrayal on nature of relationships at their workplaces.

*“I had some family issues, I discussed it with my manager, the next morning everyone was talking about it. I was so embarrassed. I do not trust to tell my stories now. Maybe it is not her fault or maybe **she did not know** how that will make me feel, but I feel disappointed. Why would another person know about what I told my manager in private? When I started, I see my manager as someone I can relate well with . It was going well at the beginning but after some time ,things changed (Ronke).*

*People gossiping here there. Everything you do, someone must gossip about it. You say one thing, another person **will twist it**. Anyway, I do my job, but I am always on my own. I always wish that whenever I find myself working with other people, let there be harmony and cooperation. I am a trained nurse and when I use to work in my country we always work as a team” (Peace).*

The findings suggest the nurses’ feelings of apprehension and concern as a result of not having the desired relationship with their managers and colleagues. In their perceptions of work relationships, the data suggest that the nurses had expectations of mutual respect and understanding built on trust that

would guarantee them a sense of belonging and involvement at work. They expectations of the role of their managers in the process of negotiating their way into the organisation. However, when these expectations were not realised, the nurses' levels of organisational socialisation seem to have been affected with a consequent impact on their collaborative activities as well as their ability to share common positive communication.

The following extract from Tunde and Ronke reinforced the suggestions that, because of the lack of a personal relationships with their managers, they became withdrawn about sharing a common view with either their managers or colleagues. The nurses report their concerns about the lack of organisational teamwork and cohesion.

*“We are human beings, all I can say is that if I am not being treated the way I am being treated, maybe I will be closer to my manager than I am at the present. When I say closer, I will think that she is someone I can share my worries with and concerns, you get? But there is a **distance kind of between** us, I can say I do the job, ooh, but that is not the issue, the problem is that the mind and the way I see my manager and my other white colleagues is not the way I wanted it to be. I wanted to be a friendly person but if someone does not want your cooperation, there is nothing you can do about it” (Tunde.)*

*“I do not even trust people at work much now because everybody **cares only for themselves**. I believe that we can be a team but sometimes no one comes to help you with things. They will rather avoid you than come to help you ...” (Ronke).*

From the findings, the nurses' concerns represent the effect that a lack of teamwork and structured processes have on their approach to work. From their point of views, the nurses' perceptions of the lack of collective actions and trust within the team led to them questioning their level of positive engagement in working to achieve a common organisational goal. The situation, therefore, presents as that of reduced relationships at work, which increases their apathy about work and their duties at work. The nurses' sense of apprehension resulting from their perceptions of distrust between them and their colleagues, including the manager, led to them drawing negative interpretations about the actions and behaviours of both their colleagues and managers.

In the following interview extracts, Azeez and Tina report situations when comments by either colleagues or their managers made them feel a sense of worthlessness based on their perceptions of sarcasm in the words used.

*“There are times when the manager would be complaining of the nature of things in the home and how this should be properly kept and maybe she does not realise it, she would say, things should not be kept as **in third-world countries**. Some of these comments make me feel she is referring to the way I do things or the way I have performed certain tasks. To me and any other person around that time, this is indirect discrimination which can **make anybody feel bad** but I will do as if I did not hear it and people will be surprised that I still do what she wants me to do with less complaints” (Azeez).*

*“They feel I am aggressive with my looks and not friendly but that’s not me. I am a very friendly and jovial person. To be honest, whenever, I travel back home, where I am respected, you see my true colours ... very friendly and good girl. These people **take away my good mood**. If you are not talking about me, why stop when I come in, it only shows that what you are talking is bad and you don’t want me to hear it or you are talking about me. **We don’t hide things** in my place, except from your enemy. Of course, it affects me and because of these types of behaviours, **I don’t trust any of them**” (Tina).*

The findings suggest a relationship between their level of trust and their perception of actions and behaviours exhibited by their colleagues and/or managers. As a result of the nurses’ perceptions of gaps in the support given to them by their managers and the low socio-emotional support from their colleagues at work, every statement made as well as actions and behaviours displayed became instances and objects of cognitive scrutiny by the nurses.

The findings suggest that events at work were perceived to display misrepresentation and biases. With their entry expectations of seeing their managers as possible confidants, the nurses’ perception of their managers not relating very well to them created further feelings of withdrawal. While the nurses had a clear understanding of the nature and type of relationship they wish to have with their managers, mainly on a close relational basis, their later perceptions of behaviours, events and processes affected their belief that this possible.

Adama and Joke, in the following comments, narrated their feelings of being put on the spot. The nurses report being made to feel like outsiders.

*“I feel that everyone feels that my knowledge is a bit limited and have little or nothing to contribute and that is why during staff meetings, **I hardly say anything** because when I am talking everyone seem to watching my mouth instead of my message and this makes me feel very ... very uncomfortable. I lose what I want to say whenever I am such funny little positions” (Adama).*

*“Sometimes I think why the manager **does not relate to me** is because she may think that I may not **keep some of their ‘secrets’**. You see, there are sometimes, we do not have the right staff levels and when we want to have inspection, they will be rushing to put things together. So, she trusts her ‘white carers’ to **cover things for her** and write good things on paper. So maybe I am not part of the **people she can trust**” (Joke),*

The nurses’ general feelings of being made to feel uncomfortable in their interactions and processes made them apprehensive about their relationship with their managers and colleagues. This thinking not only isolates them from their personal relationship with their managers but also raises doubts over their ability to carry out tasks which they could use to challenge their own competencies.

8.4.1.2 Descriptive theme ‘feelings of doubts and shock’

In evaluations of their experiences, many of the nurses reported feeling that their views and opinions were not being recognised in the decision-making processes. In the following interview responses, Ronke and Adama’ described how they felt that their efforts, skills and knowledge were being wasted because their views were not considered relevant in the decision-making process.

*“Everybody supports everyone when once we has a case, but here sometimes when some of this people (white colleagues) **are struggling** with some issues, you know, they won’t let you know but it is obvious that you see them struggling with that, when you **bring up ideas to help**, they will say ‘don’t worry am fine’ or that’s fine, I will take care of it but at the end, it will be*

an issue. Maybe they feel I am not supposed to know better than them or what, I don't know honestly" (Ronke).

*"I see the manager as not only my boss but somebody I can trust to tell my problems but if the person is not near to you, what do you do. She hardly commends me. What I think is that she **always wants to correct me** even when I have finished what am doing, just to show that I **did not achieve that on my won**. You just have to manage your life"(Adama)"*

The findings from the above reveal the nurses' reflections on their positions as nurses-in-charge. In that capacity, they feel a responsibility to represent and make decisions during their shifts. However, with feelings of micromanagement from their managers, the nurses have doubts about their competencies and skills. The nurses' responses further suggest that when their managers do not consider their suggestions, they felt that their input into the decision-making processes was neither required nor considered. In particular, in the following interview accounts, Tina and Jenny reported their doubts about lack of appreciation as nurses by both their managers and colleagues

*"The manager will be threatening openly that she will be using team leaders because there are not much nursing tasks ... yes, because the manager herself **is not a nurse**. She feels that nurses, especially black nurses are earning more than the white carers or administrators in the home. But I paid for my training and education, if they want to earn more, let them go to school, why take it out on poor black nurses. This makes me feel insecure and not wanted and appreciated sometimes. But I am a trained nurse, if I am not wanted in the nursing, they will not employ us" (Tina).*

*"I cannot even count the number of times that a mere carer has been **given the chance** to attend a training which perhaps I could have attended, and the carer will now be asked to teach us from her training. I sometimes think that left to the manager; she would not want us around. She once said that the management was planning to have more team leaders who were carers replace the nurses. I know this cannot happen, but she is always attempting to harass us. She will ask **a carer to come and teach me** what perhaps I have known years ago. But I do not care a lot that she does not want me to rise because God is protecting me here ... and **am not looking to be manager** or anything higher anyway" (Jenny).*

The nurses accounts suggest the nurses feelings that, because of differences in the professions and statuses at work, both their managers and junior colleagues do not feel a sense of group affinity. With their managers not being nurses and the junior carers not accepting their leaderships positions as nurses in-charge, the nurses felt they deliberately withhold recognition of their values and skills as nurses. This is a recognition the nurses so wished to achieve so being denied it appears to have impacted on both their personal and professional self-esteem.

In the following quotes, Irene, Azeez, Joyce and Jenny showed their disappointment and frustration as a result of frequent negative feedback, high workload, and disproportionate allocation of tasks.

*“It is easy to make a mistake, but if you make, you can be corrected so that you can get better. But with my colleagues and manager, you make a mistake, **it is a big issue**. Even when you are put under pressure at work, they will ... like you are not doing much ... please, I just want to go to work each day, do my work and go...because of these behaviours and blames, **I do not want positions**” (Irene),*

*“If other white staff like the kitchen staff or carers make mistakes, it’s like is normal but when you make mistakes **it stays in everyone’s lips** for a very long time. No one will feel good about this, my brother. They say what is good for the gander should also be for the goose. ... I think that’s how they say it. I am not afraid of learning from my mistakes, but it depends on the way this is presented to me. If you make me feel that I was stupid by making the mistake and you don’t feel that way when another person or even you **make similar mistakes**, it becomes something else. It’s all about trusting that you are being treated as human. But what do you do, when you don’t trust people, it’s difficult to work as a team” (Azeez)*

*“You can never say you know these people (UK colleagues) 100%. They will hear something about you or any mistake you would have been made ...or something like, they will put in their minds and **continue to discuss you** and what they think you have done. Even sometimes the manager **will not even let you know** what the matter is but inside you, you will know that something is going on in the home. These behaviours make you feel very uncomfortable and more disappointed even with the manager. How can you know what is wrong and how to correct it if you don’t even know what it is about? This is killing, just imagine it” (Joyce).*

*“I do not personally trust the manager even in doing the rota. In doing allocations of staff for the day, the manager will give me the **most difficult jobs** to manage and if there are new or agency staff, these are the people she will send to work with me. I will be like starting all over to induct these people before they can even know what and where things are in the home ... On top of all these, they want me also to do my paperwork and do my own allocated tasks, even **working as a carer** sometimes. On weekends, white carers would not work, they will call the manager over their personal mobile phones to **change their shifts** and without informing you, the manager will just put you on the rota for that weekend. So, with that type of behaviour, how can you trust anyone at work ... no one supports you (Jenny).*

The nurses’ responses suggest they have less intrinsic motivation, making it much less likely that they will seek further positions of trust and challenging responsibilities. Fearing that they may not get the necessary organisational social support from their colleagues and managers, the nurses avoided opportunities for upward mobility. The findings revealed that the nurses became much more particular in their task performance with less commitment toward contextual performance. These perceptions were a consequence on the nurses’ perceptions of flaws in both the procedural and distributive justice processes as they experienced them at work. The nurses’ expectations suggested a fair organisational culture that reflected learning rather than blaming. In the circumstances, therefore, the nurses felt that learning to advance in their careers was made difficult because they were not able to understand their mistakes to take corrective measures. Bose, in the following extract, expressed her feelings about discrepant ways of managing affairs involving the nurses and other issues with their colleagues.

*“They will all go out several times to smoke and I will continue working. During that short period of my official break, it would look as if I have spent the whole day on my break. Imagine that, they go out several times ... I mean the manager with even the carers and **no one will monitor** how long they stay. They will still have their normal break” (Bose).*

In addition to the experiences recounted above, Peace and Joyce, explain their feelings of pressure from the irregular flow of high workload, which tends to add to their levels of strain and anxiety.

*“For instance, there are sometimes when we have admissions of new residents and because I am the nurse-in-charge, I am supposed to receive the admission and do the necessary paperwork. But they will not even tell me before that day that there will be an admission, they will just bring the person and just hand him or her over to me. Sometimes, they bring these people even at the middle of my doing something else. If I have a lot to do that time, **no other person will help me** out, the next thing you will be hearing is that maybe **I am not organised** (Peace).*

*“I will have my medications to give as the nurse-in-charge and they will be like, Oh, you have not done this thing or that things, things the manager knows is for the carers to do. But No, they will leave them for me and go for cigarette. I will not say anything and will try to do these, but I will be under pressure. No person wants to know. Even I don’t complain, my manager is supposed to know that **I am under pressure**. I don’t think anybody will be happy with such behaviour. Sometimes, they do not think **we are human beings**” (Joyce).*

In consideration of the nurses’ original expectations, especially for a safe working environment, the nurses' evaluations of events suggest their feelings of frustration because of work processes and allocation of tasks as well as with perceptions of mismatches between the tasks they are asked to carry out and their skills. The findings also suggest that the nurses perceive obvious ethno-racial aspects of the organisational justice process as a result of prejudices.

The nurses’ sense of their managers’ indirect devaluation of their skills and lack of positive feedback, was found to impact the nurses’ motivation, performance, and sense of well-being. With feelings of a lack of positive reinforcement through encouragement and recognition of efforts, the nurses’ confidence, altruistic enthusiasm, and commitment at work appeared to diminish. In the following responses, Azeez, Ronke and Mary express their disappointment, concern, and shock about the reward systems at work.

*“We also care for each other and, when we achieve something, everybody takes care of one another. People here want the credit alone sometimes even when you are part of that success. They **won’t mention your name**. The manager will even give credit for what you have to a carer who is white even though you did that task (Azeez).*

*“But the most annoying aspect of the whole thing is that, when the situation gets messier, that’s when they will one way or the other give you the part of that job that has become difficult and at the end, you will be surprised that you will end up being gossiped about for **not being able to manage it**. It happens every time, my dear ... but when you get it right and perfect, no one mentions it how can they mention it when they don’t want you to feel good about your efforts” (Ronke)*

*“When you work for somebody, at least the person can say thank you, but my manager **do not show appreciation**, rather she will be making me doubt myself sometimes. If you say something, she will say you say that again please and I will be continuing repeating myself. Maybe I have strong accent but if she listens to me, she will understand ... Apart from that, in some cases, the people I work with make me lose my confidence, you speak one sentence, and they will all look at themselves as if you just landed from the moon. I do not like to be put in the spotlight on my own. If they **want support to me**, why not just listen to what I have to say instead of how I want to say it. It is very frustrating sometimes” (Mary).*

The incidents of perceived lack of fairness in considerations of task and performance, when the nurses feel that they were not being complimented and their achievements and rewards are sometimes ascribed to the wrong persons, leads to a lack of trust with managers and other colleagues. Many of the nurses reported having to guard against all elements of work that could make them make mistakes because of fear of the possible consequences. The following quotes from Mam and Mary show their perceptions of fear at work.

*“I don’t trust her now to deal with things that affect me. I even **fear for my pin** working under her. If I make mistake and no one tells me, it can **affect my practice** and if serious can make them to withdraw my NMC pin ... There are times when they want me to do some extra shifts as like overtime. When they call me for that, I tell them, I am not at home because I don’t want to do it. I do some extra bank shifts some other places” (Mam).*

The findings suggest clear patterns of working in fear. These feelings drive many of them to avoid extra role behaviours to support organisational goals in exceptional cases of need. This also demonstrates and reflects a lack of organisational self-esteem, meaning they do not feel happy to identify with their place of work.

*“Whenever I am ready to leave work at the end of my shift, I thank God, **carry my bag and go**. No one brings an issue that this what I said or done. At least I did not get involved a lot during the shift. Yes, it makes me feel relieved till my next shift” (Mary).*

The subsequent creation of an environment of risk aversions made the nurses play safe in the performance of their duties. This also indicates an apparent lack of trust and their perceptions of defects in both procedural and interactional justice processes.

8.4.1.3 Generation of the superordinate theme ‘process defect and trust issues’

The descriptive themes that emerged from the margin notes as part of the reflective interpretations suggest that trust is a fundamental issue in West African migrant nurses’ interaction, relationships and general experiences with their British managers and colleagues. The nurses have a background where relationships are deeply trust-based.

In that context, the nurses perceive their managers as custodians of power in the organisation where they could anchor their links of relationships and socialisation at work. However, the descriptive themes in this cluster suggest that nurses’ expectations for protective management and development of high leader-member exchange relationships in a trust model, failed to materialise.

This loss of feelings of trust increased the nurses’ feelings about the erosion of fairness in the organisational justice processes. As a result, their expectations of upward labour progression became impaired. The nurses’ sense of process defects and lack of trust impacted on their ability to fit into the diverse group at work and resulted in subsequent behavioural responses of withdrawal. The findings revealed that the nurses’ feelings that they were not involved in some decision-making processes in their organisations alienating them from the mainstream organisational discourses. The nurses’ perceptions that their managers would not assign or include them in duties that they feel they can carry out effectively suggest to them that the managers doubt their loyalty and even their skills. This thinking not only isolates them from a personal relationship with their managers but also leaves them with doubts over their ability to carry out tasks which they could use to challenge their own competencies.

While the participant nurses believe that their relationship with colleagues could be better at work, there were reservations about how this could be achieved without their managers' considerations and commitment to their welfare and dignity at work. The nurses perceived a sense of devaluation of their skills and lack of positive feedback from management and colleagues, which continuously impact their motivation, performance and sense of well-being, and their motivation to engage in organisational activities outside of their core tasks.

With feelings that there is a lack of positive reinforcement through encouragement and recognition of efforts, the nurses felt their confidence and altruistic enthusiasm and commitment at work became compromised. There is a perceived lack of organisational support among the nurses, which affects' their commitment and organisational self-esteem. In addition to their perceptions of lack of support, a deficit in trust issues and devaluation of skills, the nurses' data revealed that they are made to question their professional and self-identities. The nurses began to question their inner energies of self-motivation driven by intuitive queries on their sense of self-worth and esteem creating further questions about the significances of their roles as nurses.

8.5 Superordinate theme five: Well-being and organisational commitment

Table 8.5 Individual nurse's quotes “ wellbeing and organisational commitment”

<p>WafMNs Interview keywords, phrases and sentences relating to Well-being and organisational commitment</p>
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Keywords/Statements **	Reflective descriptive themes
<p> “never ask you for help” (Jenny) “go into your record” (Mary) “mental health” (Adama) “feel not wanted” (Azeez) “no immediate family member”(Jenny) “work in different home” (Mary) “who will pay bills” (Amie) “blame me” (Peace) “high blood pressure” (Mary) “could not cope” (Peace) “worse for you” (Adama) “doing at work”(Amie) “my mind flies away” (Bose) “reasons to throw you” (Ronke) “carry my bag and go” (Ronke) “no one around”(Ronke) “keep my job” (Tina) “without my family”(Mam) “Just do your job”(Mary) “be on my own”(Amie) “sick and weak” (Bose) “head breaking” (Mam) “sake of doing” (Joke) “already feeling stress” (Tina) “just to be at work”(Bash) “doing clinical tasks”(Bash) “try to smile” {Tina} “lots of pains” (Irene) “chatting with the residents”(Mam) “whether you improve” (Bash) “feel worthless” (Bash) “be there to support”(Amie) “hours of emotional imprisonment” (Bose) “they know your value” (Irene) “don’t feel good” (Irene) “openly threatened” (Tina) “money I make is good” (Irene) “affects me” (Irene) “I can do and go home”(Bose) “sigh of relief” (Peace) “about your marriage” (Peace) “sick and weak” (Mam) “go for agency jobs”(Joke) “memory fails me” (Mary) “I just have to be at work” (Amie) “elderly people need support”(Bose) “alone as a woman”(Bose) </p> <p> ** The textual context for each nurse’s keyword/statement is provided in the nurses’ quotes in the findings below tables 8.5. and 8.5a. </p>	<ul style="list-style-type: none"> <i>Feelings of despondency stress, emotional labour and presenteeism</i> <i>Depletion in extra role and organisational citizenship' behaviours</i>

Table 8.5a Clustering of descriptive clusters into superordinate theme “well-being and organisational commitment”

Reflective descriptive themes	Superordinate theme
<ul style="list-style-type: none"> • <i>Feelings of despondency, stress, emotional labour and presenteeism</i> • <i>Depletion in extra role and organisational citizens behaviours</i> 	<i>well-being and organisational commitment</i>

From the clustered interpretation of the descriptive themes into the superordinate theme of wellbeing and organisational commitment as shown in table (8.5a) above, the data suggest negative outcomes in the nurses’ senses of their well-being and organisational commitment. The two descriptive themes relating to the nurses’ superordinate theme on well-being and organisational commitment are described and explained in turn below with references to relevant data.

8.5.1 Descriptive theme ‘feelings of despondency, stress, emotional labour and presenteeism’

Most of the nurses reported feelings of despair while doing their jobs. From perceived disproportionate task allocation, high workloads, and lack of support as required, the nurses reported the impact of these on their emotional and physical well-being, and their sense of attachment and commitment to their organisations.

In the following extracts, Irene, Peace and Bash illustrate their feelings about experiences at work and how these make them feel and the work-related outcomes.

*“It is like when one is not appreciated in whatever you do. You **don’t feel good**, do you? Sometimes, I am very downcast because one, I am doing some tasks I am not supposed to be doing, for instance, sometimes I do the job of a Carer, doing personal care which is not part of my nursing role. But that is not even the issue, but when I do all these to show that I care about my job, they think it is what I should be doing. Or they will be thinking that I have no reason to complain. Yes, **it affects me** most of the time. **I have headache** just for these” (Irene).*

*'What can you do? There are times when I wake up, **I feel down** because of what I will meet at work, but you have to go. I don't rely on anyone at work to protect my interest in my absence, To me it reached at a point, just to show face and body but no real power for work, my brother, my heart in my hands ... so each day, I finish my work, ready to go, I breathe **a sigh of relief**. As a woman it is like fighting two battles, you think of work, you think **about your marriage**'* (Peace).

*" ... the manager chats very freely with some of the staff even with the cleaners and handy people. I feel so bad sometimes when there is a discussion, and no one wants to know whether I have any opinion on it or not ... You may even be sitting there, willing to contribute but they don't **even look your way** but when another one of them enters the room, they will welcome the person and involve the person immediately in the conversation. I feel **worthless and undermined** honestly and this has made me to sometimes withdraw. This is more painful with no immediate family member to share with when you get home"* (Bash).

Bose and Tina in their following interview quotes, highlighted how they felt when they reflect on their times at the workplace.

*"Though I feel wounded in my mind and **I feel weak** sometimes at work and you get back home you are **alone as a woman**, it is difficult ... Honestly speaking, sometimes when I wake up to go to work, **my mind flies away**. I will be like ... what will I meet today? On my off days, when they call me for overtime or cover a shift, I will tell them I am not at home, because I don't want to go and be with them...when you must **pretend that all is well** so that no one complains about how you do your work"* (Bose).

*"I would not mind with all the treatment I get at work but my problem is when you are treated like you are nobody This is more painful **with no immediate family member** to share with when in person when you get home from work, it feels lonely "* (Jenny)

*"Even some of the relatives will sometimes try to be sarcastic by saying 'please smile.' Smile with who, people that do not want you around them. But **I try to smile** then before they say that I am not taking care of people because I am not cheerful ... I try to be on my own most of the time. They make me **feel not complete**"* (Tina).

*“But **I am full of stress** most of the time. I cannot even describe my mood sometimes because sometimes it looks like my **head is breaking** but no one to tell. I have to jump from one bus to another under the cold ... I go to work sometimes feeling **sick and weak**. What can I do? I spend almost part of my evenings talking to my people back home, otherwise, it would have been too bad for me **without my family**” (Mam).*

The nurses' data revealed their feelings of despondency with occasions of emotional strains during which time they really struggled at work. The findings suggest that the nurses hide these emotions at work because they do not want others, including their managers, to know how they feel at work. This suggests that the inability to voice worries and concerns, pressures of keeping multiple jobs, reduced hours of sleep and rest, as well as the high physical demands of their jobs in the nursing homes drains the nurses' emotional resources, impacting not only their emotional but also their physical well-being. The pressures on the nurses as reported suggest the female nurses being more prone to the pressures with regards to physical absence of family members and spouses.

Ronke, Amie and Tina, in the following interview quotes, disclosed their concerns about their and many other migrant nurses' mental health issues that are not being observed and treated, as necessary. The nurses also talked about adopting self-treatment and management of their issues to keep their jobs. Many of the nurses reported their difficulties to cope or relate well with others within the circumstances to access support and are only able to self-manage their emotions.

*“My dear, a lot of foreign nurses have gone through mental health issues and they did not get the needed support, some of them **even died** because of their ill health. Some even believe that going for such services is an opportunity to give them **reasons to throw** you out easily. Because they will say you have **mental health issue**. Any time, they can treat you worse than you are. It is not easy, my dear when there is **no one around** from your family to give emotional comfort or material support. You are on your own.” (Ronke).*

*“Yeah, it's not easy, but we have to manage. I know of an African nurse who developed **mental health** ... oh, she was such a nice woman to me when. I came to this country the first time. She*

was already a senior nurse then. She showed me everywhere, to buy things, to get telephone to call my people because I was like a lost sheep. I **was crying every time** then and this woman was all I had as companion. But later on, I learnt she was in the hospital ... it all **about pressure**, my brother. We face a lot at work. But we cannot complain. They will say, oh, you are not coping so you stop work, **who will pay your bills. If your husband is around, you can say, well, he can be there to support** ... so we struggle to keep going on” (Amie).

“So, you see, it is not my desire to be a manager. They will not even give it to me. So why worry about that ...I am **already feeling stress** when I try to do my bits in the home, what of when they say take over the whole nursing home. With no support, what will it be like? I will be in more trouble...maybe go mental” (laughing) (Tina).

“Even if I am given as post, I will not take, oooh (laughs). I have two of my friends from my country, hmmm, they ran away after some time when they were appointed deputy manager in their nursing homes ... **they could not cope**. They were not supported ... gossiping and pressure. I know of many black nurses here who if you know them before, you will not recognise them now ... my brother, it is stress. In Africa, if you are a manager, you can feel it with happiness ... but here ... hmmm, **you carry sickness on yourself ... No help from anybody** and you have to work whether you **well or not**” (Peace).

These findings suggest that the nurses were not keen on monitoring their emotional and, by extension, mental health even when it was obvious to them that they were struggling. However, their concerns on these feelings of ill health ,according to the findings ,were made complex with their reluctance to seek medical support. The nurses were of the perceptions that with a possible record of mental ill health on the files, the chances of them maintaining or getting jobs would become slimmer. The nurses consider the impact of these situations on not only their emotional wellbeing but also their financial and economic circumstances. There is nothing from the research findings to suggest that the nurses have any effective safeguards in the form of support regarding their mental wellbeing. They continue to show up at work regardless. This is even in their knowledge that they struggle to cope during these periods.

“No, count me out, I would not take any manager position. Even now, I am just keeping my head, but I cannot even say I don’t have **high blood pressure** at my age, but I don’t like to phone in sick at work. It will **go into your record** and you know they will make a lot noise about

it but white carers can stay off work for weeks, do they care? They don't ask if I would like any position. If the white carers that I work with are nurses, they would be managers by now" (Mary).

Peace and Mary's comments suggest the nurses' sense of resignation to fate and diminished expectations for upward labour mobility at work and the further challenges of continuing to work. Irene in the quotes below expresses even more strongly the feeling of lack of care and respect.

*"There is no other way to say it than that whatever people do to others will come back to them. It makes **me feel frustrated**, to tell you the truth. When you think somebody, you trust cannot show that trust, it can **be a lot of pain**. One thing, my brother, you should know is that, as a black in this country from a foreign country, even if you die doing your job, nobody cares. They will take it a normal thing and the next day, they will employ another person and **forget about you**."* (Irene).

The findings suggest that the migrant nurses face challenges in attempting to work on their mental health and keeping their jobs and most of them bear their pains in silences. The data also presented the nurses' fears of the long-term effects of their shared health experiences and their capacity to continue to work but the concerning striking insight of these findings is the nurses' reluctance to access health support for fear of losing their jobs.

Adama, Mary and Joke in the following quotes explained their and friends' experiences of their struggles because of their experiences at work and the fears of mentioning these health-related experiences.

*"I don't think that some people here understand the kind of pain migrant nurses face. If you **talk about your mental health**, they will make it **worse for you** and you will not even get a job ... hmmm, **people are careful** here, ooh. When you tell even your manager about any issues, it **will become news** everywhere and you will not know where it started or where it will end. All these things happen, you regret. When people think you are second class even when you are doing your best"* (Adama).

*“I have to meet up with my other jobs. The only time I have to rest, I use it to go to town centre to buy my items for the house for the week. You see, I have no time for myself. There was a day, I wore another of my workplace uniforms when I was supposed **to work in a different home** ... (laughs) ... I only realised when I was in the bus. I have to get down to go home and change. My dear, sometimes, **my memory fails me** with a lot of things to think about” (Mary).*

*“I have to **cut down on my hours** because sometimes I cannot cope. Sometimes when I go for agency jobs, I will be feeling tired and sometimes I will go into the toilet and cry. I am in a developed country, people at home are happy I am here but they do not know what I go through, my brother, it is not easy” (Joke).*

The findings not only revealed that many nurses experience pressures at work but that these pressures result in depletion of their emotional and physical resources.

8.5.2 Descriptive theme ‘depletion in extra role and organisational citizenship behaviours’

Many of the participants reported consequences of their perceptions of lack of recognition and value as well as support at work. and their reasons why they continued to stay at work. In the following quotes, Peace, Bose, Amie, Mam and Jenny recall their feelings when they remember their times at work.

*“I was just working because I have to work to get paid, but my mind was **no more at work**. It is very bad sometimes when people (managers/colleagues) make you feel that you don’t know what you are doing just because of their own mistakes. How can somebody **blame me** for something I do not know about ... I did not bargain for this, everyone, especially my manager and her white carers **do not see any good thing**, but only my mistakes and always highlighting them ... I wish these things I am saying here, I can say it to them to let them know that they are killing me slowly with their behaviours” (Peace).*

*Sometimes, I wish that everything that, nurses working in nursing homes here have chance to do their real work... but that is not the case, you know we are sometimes referred to as “BBC”(laughs) because of our work in nursing homes..... I did not train be doing only personal care only...but that is what we do...and people still **do not appreciate**. I do only what **I can do and go home**”(Bose)*

*“The true situation is that I wish I don’t have to go to work sometimes. There is no option than **to go and finish my shift** if I can and go home. It is not something you want to do or feel because, as a professional, I am trained to serve and be on my duty with a fresh mind because I am a nurse but I don’t feel valued at work.” (Amie).*

*‘... they don’t have patience to listen to you before making judgment on you ... When I say something, they will say ok but will not even follow what you suggested, or they will go and ask another person...sometimes the only time I feel happy at work is when I am **chatting with the residents**. You know, they tell you their stories. It makes you feel happy ’ (Mam).*

*“What happens to me sometimes is that **I just have to go to work**.... I am a nurse and where I come from, we respect and care for our parents even when they are very old. In fact, that’s when we love them more because you have to give back to them all their sacrifices and efforts in bringing you up to be somebody. So here I see those residents as my own parents that why I continue to do all the good things I can afford to support them even when no one appreciates me” (Jenny).*

In the following response, Tina demonstrated her fears at work and being sensitive to her routines at work, being extra careful as a result of the prevalence of the blame culture.

*“I just have to behave myself in **order to keep my job**. They do all these to me because they know, I am still under their sponsorship license (authority to work usually granted by the employer from the home office). Do you know someone **has openly threatened** me once that they can make lose my pin because it is easy for them to say I did this or that ... so I am taking it je-je (easy) with them now” (Tina).*

It is evident from the findings that the nurses were also doing their jobs because of the possible fear of reprimands as well as fear of loss of income, hence their increased sense of presentism in their places of work. The findings also suggest that the nurses consider and perceive their work environments as sustaining a culture of blame rather than being a learning and supportive organisational environment.

In a similar feeling, Ronke and Mary in the interview quotes below explain their deliberate actions of avoiding offering their services when off work to show their displeasure at work .

*“Whenever they call me to go and cover when somebody phones in sick, I will tell them I am **not around** because I don’t want to go. I will even use that time to go and do agency work. They pay me more and it is better for me because they don’t know **to start to gossip** that I did or did not do this. I just go, do my work and **carry my bag and go home** and I will not go in pain of what someone had done or said to me that day...let them get agency or do it themselves ... it is hard work, my brother” (Ronke).*

*“She does not want to employ people because she is saving money for them (?) ... because if she saves money, they will give her bonus or increase her salary at the end of the year. So she makes people like me work like donkeys ... Yet no thank you. I want her to pay agency cover, that is why **I refuse to go** and do overtime to cover shift. You know when an agency staff covers shift, the home pays even double, let her spend money. It is less stressful to go do extra work with agency. **Just do your job** and go home” (Mary).*

The findings suggest that the nurses in their perceptions of negative experiences at work showed levels of reduced commitment to their goals of their organisations. The findings revealed that the nurses’ affective commitment levels were more negatively affected just as the data suggest decreased levels in the nurses’ contextual job performances. The nurses would rather excuse themselves by feigning sicknesses when called to do “extra hours” or “cover shifts” which require extra sacrifices at their primary places of work. The nurses’ behaviours demonstrated that the nurses were happy to work in different nursing homes where they feel no attachment rather than offering their services to the benefit of their primary organisation when they were not obliged to, such as their off days. Mary’s quote suggests that refusing to do overtime was a way of restoring equity as the manager stood to gain financially from Mary’s support. This revealed Mary’s awareness of the potential selfish interest of her manager because in her perception that the manager’s use of agency staff would cost more to the organisation and subsequently affect the manager’s annual bonus on saving money from her budget.

Bash, Jenny, and Amie expressed their disappointment and concerns about lack of exposure to training and how they responded to their feelings.

*“I don’t think I am **using or sharing my skills** and knowledge as much as I wish ... it’s like I am rusting, even I don’t know much what current issues in my profession are ... you know, in*

*nursing homes, even though you do some clinical and nursing procedures on residents, you are not exactly **doing clinical tasks**. I don't think my manager cares **whether you improve** or not ... **no support to move** on your career, you are made to **feel not wanted**, no one recognises what you do, no one tells you anything" (Bash).*

*You know what, the carers (white) can **never ask you for help** when other people are there even if they don't know what to do ... but they can ask you where there is no one around. So I said to myself ... because she doesn't want to be seen seeking for my professional knowledge I pretend also that I am not seeing that she needs helpwho loses, it is not me" (Jenny).*

*"Yes, ooh, if I say is not affecting my career, I would be lying, you know as a nurse, you should be developing yourself by doing things so if you are not practicing the things you do as a nurse, and you will not be current...sometimes I ask myself what am I doing at work. The manager feels better to **send a carer or team leader** to a meeting instead of the nurse. So, I keep the **things I know to myself** and let the person they send for training come and do it. **I do the basic things** at work and be on my own till the time comes to go home " (Amie).*

The nurses' report of their perception of their work environment did not suggest an environment in which they hope to grow their careers from. Apart from the findings that their work settings as nursing homes do not operate as normal hospital environments with necessary clinical equipment for conventional clinical procedures, most of the nurses' report not being able to access additional relevant nursing training as expected. In the absence of access to information resources with which to make contributions in the organisational decision-making process, the nurses feel that their managers and other white carer colleagues' sole intentions are to deflate their self-esteem and sense of professional competences.

The findings suggest the nurses' perceptions of lack of development in mentoring relationships between them and their managers and even deliberate stalling of their careers and personal professional development, hence the nurses increased feelings of despondency, apathy, and lack of trust between them and their managers. The nurses' feelings that they were not being included in the mainstream organisation's processes led to an eventual chain of responses, such as avoidance coping and targeted retaliatory behaviours, including a diminished pro-social sense of knowledge sharing. The findings suggest two folds to this loss of motivation to share their knowledge at work, including the nurses' feelings of self-doubt

about their current professional competences due to little or no routine relevant professional training being available to them and as a way of showing their displeasure about their experiences at work. The findings suggest the nurses' perceptions that their opinions do not matter in the decision-making processes drive them away from effective engagement with mainstream organisational issues at work. The nurses feel that they are not involved in sharing information that would equip them to contribute to their workplaces.

Driving further understanding of their immediate responses to their perceived negative experiences at work, the nurses' data revealed their nurses' subjective renegotiations of exchange expectations. In the following quotes, Joke, Irene and Bose emphasised their current increased need for financial rewards as a reason for being at work despite their experiences at work.

*“I am here now **to make money**, I am now getting fully involved in making money. I work in different other nursing homes now but it is affecting me. I don't feel well sometimes but I have to go to work. If you phone in sick, you lose money ... yes, I now work at other nursing homes but **I am not enjoying** it much. I feel tired every time. When my people back home request money, they don't know what I am going through to get the money. So it is like I am working for members of my family back home. What of my own life...**but without them**, it will be worse, oooh, so I push on.... “If you do not go to work, **you are not paid**. So, you have to go to work.” (Bose).*

*“What do I do, I just have to be there, you know hours now, if in my country and I feel like that, I will just relax at home, at the end of the month, I will still get my pay but here, no work no pay. So that's why I still go **to get my money** ... In fact, I now do the job just for the sake of doing the job to get my pay ... It's not easy, my brother ... long hours, no life of your own. I get worn out whenever I come back from work thinking of the backbiting, blames, isolation and **pressures at work**” (Joke).*

*“My issue is with the people I work with who do not treat me as a human being sometimes ; my family gives me the hope I need. I am always calling my family back home but the **money I make is good and fulfils expectations** at home even though there are loads of pains in making this money here in the UK.... I know it not all bad as such because I can say that, I am meeting up with my financial commitment **with my other jobs**””(Irene).*

The data suggests that the nurses’ engagements with multiple jobs were outcomes of their perception that their expectations to improve on their knowledge and skill would not materialise. However, the finding revealed that the nurses were willing to offer their extra efforts in different nursing homes rather than their primary places of employments. This was evident in the nurses’ willingness to reject calls to work and earn extra income at their primary places of work on an “extra or cover” hours basis in favour of taking up offers to work for “agencies” at the time at a different location.

These findings suggest that the nurses’ sense of organisational citizenship' behaviour was impacted as result of their perceptions of experiences at work. This behavioural response appears to be a consequence of the nurses’ perceptions that their premigration expectations of enhancing their skills and gaining a safe working environment, (as evidenced in Study One) were not met. The nurses’ responses had an impact on their organisations as well as themselves.

8.5.3 Generation of the superordinate theme ‘well-being and organisational commitment’

In their perceptions of negative experiences including feelings of exclusion, undervaluation and negative feedback and trust deficit issues in relation to interactional, procedural, and distributive levels of the organisational justice system at work, the nurses’ perception of their work environment suggests both human and physical stressors at work, which affected their “presence” and engagement. With a perceived lack of cooperation, inclusion and teamwork that resulted in their loss of trust within the interactional processes, the nurses felt that time spent at work negatively affected their mood and esteem instead of engaging them. The findings suggest that the nurses’ perceptions of not getting adequate organisational social support, particularly from their managers and colleagues, impacted their emotional and cognitive resources. This was caused by the nurses’ feelings that their voices were not recognised or valued and that their feelings were not considered, making them develop a sense of loss of value and organisational self-esteem as well as the inevitable loss of job satisfaction. In addition to the nurses’ feelings of loss of personal value and devaluation of their skills and knowledge, their perceptions of being involved in extra workloads beyond their job descriptions impacted their well-being. This is a result of the finding that the nurses experiences of psychological strain and despondency tasked their emotional and physical resources.

The nurses’ inability to seek support was found to be dependent on their perceptions of its possible impact on their work records, with further impact on their career and material well-being. Hence, they resorted to self-management of their emotions and associated pains. The nurses fear that seeking support would taint their health records and impact their chances of employment with consequences for their economic well-being and self-esteem. As a result, they self-manage or completely ignore their physical and mental distress. As a result of these perceptions of their experiences, the findings suggest the nurses engaged in self-withdrawal and avoidance of group cohesion at work. This response created continuous anxious moments for the nurses because of their inability to access further practical and psycho-social support resources either for their work or for their personal well-being with constant dips in their emotions at work.

As a result of the nurses' perceptions and decline in their organisational self-esteem, they showed a lack of the sense of organisational citizenship' behaviours, which manifested in such acts as avoiding the sharing of professional tacit knowledge with colleagues when necessary. The nurses' sense of a lack of organisational self-esteem, which had consequences for the nurses' organisational commitment, was demonstrated by their engagement with employment in other organisations. While it is evident that the nurses' responses could pass as the proximal natural responses to balance exchange relationship issues of equity, the findings suggested a possible relationship between migrants' value judgments, organisational self-esteem, pro-social behaviours, and restoration of equity.

In the following findings, the results of how the nurses were able to stay on the job despite perceptions of negative events and actions at work are presented. From the individual nurses'

margin notes (keywords, phrases, and sentences) presented in table 8.6 to the reflective descriptive themes, presented in table 8.6a, the researcher constructed the superordinate theme of positive reframing.

8.6. Superordinate Theme Six: Positive reframing

Table 8.6 Individual nurses' quotes "positive reframing"

WAFMNs Interview keywords, phrases and sentences relating to positive reframing	
Keywords/Statements **	Reflective descriptive themes
"chatting with your own father"(Ronke) "Golden people" (Adama) "We respect old age" (Jenny) "Care for our parents" (Joke) "Extended family" (Jenny) "Our extended family" (Jenny) "Knowing that God exists" (Irene) "As a woman" (Joke) "Can laugh with" (Ronke) "Family meeting" (Ronke) "To get enough money" (Bose) "My children education" (Bose) "Family reunion" (Tunde) "my background" (Mam) "Technology" (Joke) "Share a lot" (Jenny) "Becoming a matron" (Adama) "Appointed on a committee" (Adama) "Equally doing better" (Amie) "Am not developing" (Amie) "Without qualification" (Peace) "I get British citizenship" (Bose) "Family issues" (Jenny) "Abba father" (Ronke) "Provide for family" (Azeez) "look up to go God" (Joyce) "make me laugh" (Bash) "forget what you are facing at work" (Ronke) "make some money" (Ronke) "church gives me joy" (Mary) "place of worship" (Mam) "it is my local food" (Bash) "always a woman of God" (Peace) "is all about the pound " (Jenny) "let me have the money" (Tina) "not confident to go home now" (Bose)	<ul style="list-style-type: none"> • Social-cultural and spiritual sense of being • Renegotiations of their exchange expectations
** The textual context for each nurses' keyword/statement is provided in the nurses' quotes in the findings below tables 8.6 and 8.6a	

Table 8.6a Clustering of descriptive themes into superordinate theme “Positive reframing”

Reflective descriptive themes	Superordinate theme
<ul style="list-style-type: none">• Social-cultural and spiritual sense of being• Renegotiations of their exchange expectations	Positive reframing

The two descriptive themes relating to the nurses’ superordinate theme on positive reframing are explained in turn below with reference to relevant data.

8.6.1 Descriptive theme ‘social-cultural and spiritual sense of being’

In the following extracts, Adama, Jenny, Bash, and Ronke reported their positive feelings in their relationship and support of the elderly residents in their nursing homes.

*“How many white nurses do you see in the nursing homes? When they are in the nursing homes, they are there as managers. Dealing with only paperwork. We do the ‘dirty jobs,’ don’t we? We take the elderly people as **golden people**. We give them the best care we can. That is what we do in Africa. We **respect old age**. My job of taking care of the elderly people remains in my mind and **gives me joy** and satisfaction despite what I go through at work” (Adama).*

*“I am a nurse and where I come from, we respect and **care for our parents** even when they are very old. In fact, that’s when we love them more because you give back to them all their sacrifices and efforts in bringing you up to be somebody. So here I see those residents as **my own parents** that why I continue to do all the good things I can afford to support them even when no one appreciates me ... (Jenny),*

These findings suggest that some aspects of the job offered senses of job satisfaction and personal fulfilment for the nurses. The nurses related their duty of care of the elderly persons at the nursing homes to taking care of their elderly parents in Africa.

*“Those guys (elderly residents) **make me laugh** most times. Honestly, I like spending time with some of them. Though some of them could be very difficult to manage, but there are a pretty good number I enjoy company with. Especially when they tell you history... yeah, many of them*

tell good stories of their time in their careers. For instance, some of them who were doctors, pilots and engineers will tell very good stories” (Bash).

*“It was like sometimes you **forget what you are facing at work** when some of the residents share jokes with you ... yes, sometimes I wish I could be just talking and sharing stories with them ... just like **chatting with your own father** or mother. But even at that, when some people see that you are having a good conversation which makes you feel good, they will come tell you ... hmmm, I think ... so ... so and so is OK. Maybe we can do other things” (Ronke).*

These findings suggest the nurses’ feelings and senses of personal fulfilment and purpose in their support of the elderly residents which give them an extra sense of intrinsic job satisfaction. This goes to suggest that the nurses’ negative behavioural responses to their negative feelings at work had no direct consequence on the service users but targeted at their managers and colleagues whose interests they do not wish to protect.

These findings also highlighted aspects of the nurses’ attachment to family lives, respect and consideration for the elderly members of their society. The findings suggest that, when the nurses enjoyed this aspect of care of the elderly within the context of social activity, it provided not only feelings of intrinsic job satisfaction but also a sense of identity in relation to how they were socio-culturally brought up to relate with the elderly members of their communities. There was a relationship between the care of the elderly in their care homes and the nurses’ sense not only of family lives but also of communal social relevance. While the nurses did not demonstrate affective commitment to their organisations, they showed a desire to remain at work because of their passion for the elderly, indicating their normative organisational commitment.

*“No ... No ... No... In all honesty and to the God I serve ... Though I feel wounded in my mind and I feel weak sometimes at work, I remain committed to my **care for our residents**. My profession is to treat and care. So, I do not allow what happens between me and the manager or colleagues or the way they treat me to affect my work” (Joke).*

In their desire for socio-emotional support, Bash, Tunde, Jenny and Bose, in the following interview extracts, explained their attachment to their families back in their home countries and the support that such contacts give them.

*“I will one day go back home even if I die here because my culture forbids me to be buried in a foreign land ... hahaha (laughter), yes, ooh. You don’t bury a prince in a foreign land, know what I mean, otherwise I will wake up and walk back home ... ha-ha (further laughter). I keep **my contact with my people** back home, but if I don’t learn to adjust, I may not cope and therefore not realise my dreams ... the British dream” (Bash).*

*“What I try to do is also meet with my folks here in the UK for **family reunions** at times where people and their families gather during occasions. ‘It is such a great time to interact and feel home” (Tunde).*

*“When you are in the position, we nurses’ find ourselves in a foreign country, it is then you know the importance of your own people ... I mean your own blood where you have a **lot of respect**. Even in groups of people from your place, **they know your value** ... my family is my rock with their prayers and support” (Jenny)*

*“I like feeling African each time, I go to our **community meetings**. I don’t miss those because they are my only hope now. Even when I go there, you will get information on where to get African food items which I like a lot ... Yes. I feel home when I meet other Africans. I am working on my final papers for naturalisation, so I get that, then I can have two homes, Britain and Africa and my family can join” (Bose).*

The findings suggest the nurses’ attachment to ethnic values of communal being. With evidence of the nurses’ reliance on communal social engagements, they showed senses and feelings of belonging and self-recognition with their associations and socio-cultural attachments to their ethnic communities. These were particularly evident with Tunde’s quote, which signified a great sense of passion and feelings of home for him. To the nurses, ethnic communal social gatherings provide them with a communal sense of protection and reassurances. There was a re-enforcement of engagement with their families back home and an increased urge to keep in touch with them. The nurses, therefore, feel more social security by meeting and identifying with their ethnic communal groups, especially when time permits from their multiple work engagements. The sense of attachment to families and family lives back home fulfils a certain kind of need for the nurses.

In a similar search for identity, Mam and Bash explain how fulfilling it was for them to have access to their native ethnically sourced food items. Mam narrated her feelings of embarrassment with a perception that she was sarcastically ridiculed by colleagues when she brought her ethnic for her lunch at work.

*“When I was bringing my food to work, some of them behaved as if I am eating rotten materials. These people will not even tell you in your front that this is what or how they feel about your food but saying ...hmm, do you eat that? So, I stopped bringing the food because it like insulting **my background** . It is the way it was being discussed that annoyed me very much ... hmm, but it cannot stop me eating my favourite meal, oooh (laughs)” (Mam).*

*“I miss my local food that my wife prepares for me. I don’t know how to cook but I know how to eat. So, if there is anything, I am missing very much **it is my local food**. I eat very heavy meals but what we eat at work sometimes, is not for my taste, no peppers, you know what I mean. But I think, I am adjusting now but I put my own spices” (Bash).*

The above data suggests a clear demarcation between the symbols and values of cultures. While Mam’s passion and identification with aspects of her cultural symbols offered a sense of joy and fulfilment, she equally learned that this would not convey similarly well with her colleagues. In considering aspects of social support, Mary, Bose and Azeez recounted the pains they face with family-related issues as migrants. They reported the conflict they face as a result of absence from home. These were particularly evident in the following quotes from their interview accounts:

*“But let me tell you the truth, one thing that is even killing our black nurses here is that we all pretend that everything is well with us because sometimes you feel that when you tell another person your problems, they will take it to everywhere. Some of us are having problems with **husbands back home**, especially if he has not joined you here. Some people their husbands have more than one wife back home in Africa. So, while they suffer at work, they also suffer from thinking about their marriages. You see what I mean” (Mary).*

*“**I just shed tears**. I am going through a lot at the moment, my husband even though he supported my coming here, but now he thinks otherwise, so where do I get the support? (further rhetorical question). The **family is the backbone** of any woman in my place, in fact, if you are*

not married or with a family, no matter your achievement as a woman, you are an outcast, so you see what I mean” (Bose).

*”I try not to follow them to moan because as a man the way I handle matters is apparently different from the way they handle such matters. In my place we used to say, ‘market women’ but we don’t say ‘market men.’ It means that women go to market and talk a lot, but we men stay behind to reason much better. As a man, I know my role in my family, to provide for them. I can stay outside for a long time as long as **I provide for my family**, but women ... hmmm. Your husband will leave you and **marry another woman** if you stay outside for a long time (laughs)” (Azeez).*

Many of the nurse participants in the research are women. The position and social relationships and roles of women in Africa are very reserved and sensitive even in marriages. Many of the nurses reinforce these beliefs, with the female nurses feeling more concerned about the consequences of their migration and absences from their families, both nuclear and extended. Aspects of these findings suggest the consequences of the nurses’ self-preservation. As Mary’s quotes above suggest, some of the nurses would rather keep quiet and self-manage emotions than seek support from friends. This shows that there is a strong attachment to family and communal lives, rather than confiding in friends on matters of family consequences.

While the nurses feel the impact of their absence from home, Joke, Peace and Jenny, in the following excerpts, recollected different ways of coping with reaching out to their families back in their home countries. The nurses report a routine way of engaging with the families through telephone and other social media sources.

*“I told you, I spend a lot of my time **on the phone to call** my family back home. As a woman, we feel these things more than the men. **Thank God for technology**, Facebook, WhatsApp, etc. I don’t use these things before because I said what am I doing with these, but my daughter made me to start using them, oooh. I use them with my husband, children, cousins and other relatives because my husband is not here with me” (Joke).*

*“When I feel bad from work and I come back to my house here, I will just pick the phone to hear some voices from my **people back home**, otherwise I will go mad. I was saying to myself*

that what if it was in those days when there are no phones, emails, or other modern technology. Some people will not cope, oooh, my dear” (Peace).

*“My daughter will always tell me to be strong ... ha-ha ... haahaaa, what I will do. When I hear such consoling words, they make me feel better again. Also, as the first daughter in my family, I also coordinate family meetings from here to solve **some family issues** whenever they arise. That is part of **our extended family** systems ... even when you are married, you are expected to still be part of your original family. **We share a lot**” (Jenny).*

The findings from the nurses’ data suggest constant contact with their families back home. Using media technology such as Facebook, WhatsApp and Instagram keep the nurses closely in touch with their families back in Africa. Even though most of the nurses were not conversant with media technology before, the pressures and need to adjust and cope to have better well-being have driven them into accepting and using media technology.

In the search for external social support, Irene, Ronke, Joyce reported their closeness to their church organisations as a means of succour from their experiences at work. Many of the nurses reported how the church environments provide a source of comfort and hope for them

*“Going to the churches was like a tonic to most of us. I know many people here do not go to church. At least, **knowing that God exists** is especially important for me. God is the only thing that cannot disappoint you and, in His presence, there is joy and freedom” (Irene),*

*“I do my own things, go to church sing glory to my father God. This makes me very, very happy each time I am in the presence of my ‘**Abba**’ father. I forget my worries. I go to my husband’s place **family meeting** here but sometimes I am very tired to attend. When you go for such meetings, at least you see people you **can laugh with**” (Ronke).*

*“When there is no one for you, there is only one place to go, **look up to God**. He knows why I am here. Even though I see myself as a strong woman, sometimes I feel bad but any time I have time to go to church, I got myself back. It is not every time that I go to church, though. We don’t have time because of this work. Most of us work on weekends, that’s why, so we don’t have time to go to church every Sunday” (Joyce).*

Many of the nurses found support through their spiritual attachment and relationship with their local church groups and ethnic associations. This type of engagement served as a buffer and reinforced their senses of self-esteem, personality, identity, and well-being. The church and local ethnic associations provide alternatives to the expectations of communal feelings that they found to be non-existent at their workplaces. The nurses socialise with their church members, in addition to achieving spiritual gains by attending church activities where they can share experiences with non-judgmental members. The nurses' attendance at churches was strengthened by the memberships of the church who are mostly from Africa.

In the following interview quotes, Mam, Mary, and Peace recollected how meetings in their places of worship make them feel positive.

*"I like staying alone sometimes, but at times it is not easy. I don't go to parties, I don't go to clubs, I don't go to pubs, so the only place sometimes that I can say make me interact well with people is at the **place of worship**. I know is not always that I go because of time and my work but whenever I go, I am happy when I meet people of my type" (Mam).*

*"Hmmm, if you ask me, I will say that one of the things keeping my mind is when I go to church. It is not that there something so special but even singing in the **church gives me joy**. You will see other people and the way they talk to you makes you feel better" (Mary).*

*"I am **always a woman of God**. So, there is no other place that I can find peace like my name except with God. I am hoping that my family will be complete together for us to worship God together ... I share some of my experiences with my priest, Lucky enough, he is from my country. It helps a lot" (Peace).*

The nurses' attendance at churches was strengthened by the church members, who are mostly from Africa. This made it possible for the nurses to interact and socialise freely. The nurses felt at ease sharing their experiences with them. The nurses also feel that the church members are non-judgmental and so were able to share their experiences with them. While the church conventionally represents a place of worship, they also feel the church is a place of refuge and communal interactions.

8.6.2 Descriptive theme ‘renegotiations of exchange expectations’

Many of the nurses reported how they currently feel about their expected and current relationships with managers and colleagues. Bose, Ronke and Mary’s extracts below highlight their current self-renegotiated exchange expectations and efforts to make money to meet their personal, family and communal expectations in home countries. .

*“When my family are happy, I am happy too. Especially if I know that it is through my efforts that **they are comfortable**. They are proud of me and I am happy. If I have to say the truth, the money I make, I think is worth what I am experiencing. ... my plans? Well, my plan is more to get my family to be happy ... what else. Nothing more and nothing less. If I manage **to get enough money**, maybe I will be able to set up a pharmacy shop in my country. This is very profitable and then I can get **my children education**. There is nothing else for me here, to be honest. I am not praying to be a manager or to be a director, so I am only doing my job to benefit the residents and **get my money**” (Bose).*

*“Yes, I am not going anywhere, my brother, but if I don’t get any other thing, at least let me work and **make some money**. That will save my pride at home. If you go back home, you will see that many people are doing many things. So, for you to meet up, you make the money. I work any hours which is not even good for my health. But what can you do?” (Ronke)*

The findings suggest that many of the nurses have no intentions either to leave work or immediately return to their home countries despite perceived experiences at work. The nurses’ idea of going back to their native West Africa seemed doubtful because of their perceptions of lost career honours and professional improvements. The nurses, in their perceptions, rationalised their earlier expectations to fit into their present realities. From their original intentions and expectations of developing relational exchanges at work, the nurses diverted their goals toward greater attachment to making money, which represents more of a transactional exchange relationship.

While the nurses feel the health consequences of multiple employment, their considerations of their ascribed responsibilities back home requiring materials and economic resources make the chase for money a socially important prize. These considerations further reveal the social leverage that the acquisition of material wealth offers in West African society. Tina, Bose, and Jenny, in the following extracts, like many other nurses, report that, while they feel the pains of their experiences, they find

satisfaction in making additional money and are committed to just making the money much more than any other motivation to be at work.

*“Sometimes they tell you even in your face that you like money and we are here for the money. Who does not like money? After all, I work for the money. I don’t claim benefit, so I make the money. At least if I don’t have any other thing, **let me have the money** for my responsibilities at home” (Tina).*

*“I am here now **to make money**; I am now getting fully involved in making money. I work in different other nursing homes now, but it is affecting me. I don’t feel well sometimes but I have to go to work. If you phone in sick, you lose money ... yes, I now work at other nursing homes, but **I am not enjoying** it much. I feel tired every time. When my people back home request money, they don’t know what I am going through to get the money. So, it is like I am working for members of my family back home. What of my own life...**but without them**, it will be worse, oooh, so I push on” (Bose).*

*“I work for agency sometimes and they pay even more ... you don’t have paperwork to do. Just report at work, do your hours, and go home. I know it is sometimes very difficult, but it **is all about the pound**. You have to show that you are in the UK when you get home. So, I try to make the money before I am too old” (Jenny).*

Many of the nurses reported that going back to home countries immediately is not an option for them. In the following interview extracts, Joyce and Bose reported that events in their home countries have overtaken their plans and expectations.

*“I don’t even want to go back home permanently, no matter the situation. Some of my mates at **home have moved on**, some with higher positions. Though they still value me whenever I travel home but I know how I feel inside of me. Some of my mates have people they are managing. Some of them are now matrons in the hospitals but I have my faith in God that one day, it will be all right. I want to do my job to my utmost best. I cannot go home now; I do not even have **any additional qualifications** yet ... but I miss my family a lot. I am a mother and woman and I know how it feels to be without your family” (Joyce).*

“When you think that maybe you can manage, but when you now see that other people at home are competing with you who is overseas, especially in England, you must show you have

*something to home with ... apart from my children's education, I cannot say I am **not confident to go home now**. ... If I succeed to bring my children here to study, that is good” (Bose).*

The nurses' data further shows how they feel about return migration. In the sense of peer comparisons, the nurses feel that they have lost a lot in terms of their careers when compared to the perceived achievements of their peers back in their home countries. The drive for return migration was found to be slowed due to the nurses' perceptions that they have not achieved their core aspirations regarding their careers.

In comparing their achievements with their peers back home, most of the nurses now prefer to stay in the United Kingdom rather than going back with little or no addition to their skills and knowledge. These and other responses from the nurses on their feelings of not completely feeling like members of the organisational family lead to perceptions of exclusion and disengagement, making their relational attachment within the home difficult.

In the following quotes, Adama and Amie recount their regrets and feelings that they are not able to meet the basic reasons and expectations of coming to the United Kingdom.

*“I ask myself questions sometimes about my career. You know, I am very much in love with my profession as a nurse and when I was in my country in Africa, I was dreaming of **becoming a matron** in one of our hospitals one day. In fact, as we speak some of my friends back home have moved. Only yesterday, one of my friends called me to inform me that she has been **appointed on the committee** to represent my country in one international assignment” (Adama).*

*“Most of our colleagues in Africa are **equally doing better**, but I cannot say that of myself. I know I am getting paid in pounds but there are other things we value in Africa. For instance, any person can have money but not everyone can have education and knowledge. **Here I am not developing** actually; I feel down and keep pushing it ...” (Amie).*

*“I still have hopes here. Where else would I go? I don't even want to go back home no matter the situation. Some of my mates at home have moved on, some with higher positions. We have pride in our family, you know. They are proud I am in the UK but going home **without qualifications** is not something they will be proud of.... maybe if **I get British citizenship**, I will relax and feel better” (Peace).*

In comparing their achievements with their peers back home, most of the nurses now prefer to stay in the United Kingdom rather than going back with little or no addition to their skills and knowledge. In reframing their thoughts against social values, the findings from the nurses' data revealed their thoughts that re-enforcing efforts to earn British citizenship would be appropriate compensation for not improving on their careers and skills. With such feelings of compensatory options, the nurses feel much better when considering their social ratings back home in their countries. The nurses would rather rebuild their lives in the United Kingdom and visit home occasionally than face their peers back home who have advanced in their careers. The nurses' sense of "saving their faces" is further interpreted by their cultural dispositions to protect personal and family social images,

8.6.3 Generation of the superordinate theme 'positive reframing'

The findings of the research suggest the nurses' perceptions of conflicts between their premigration expectations of safe working environments, exposure to quality training for skills and knowledge improvements as positive relational exchanges at work and their current experiences at work. While the nurses felt that even against the odds, their financial expectations are being met, they also reported feelings of exposure to vulnerable work environments that tasked their emotions and wellbeing. The nurses' initial responses to their perceptions of experiences at work was self-withdrawal characterised by presenteeism. This approach had an impact on the nurses because it further alienated them from organisational social support with indirect outcomes on their ability to access organisational resources and information.

The nurses were able to continue in their jobs despite perceptions of negative events and actions at work by engaging in strategies to cushion their experiences through the reframing of thoughts and the drive for self-identity in dealing with their perceptions. The general feelings moved from despondency and avoidance measures to positive framing of events and situations, feeling much better away from work where they adopt measures to cushion the experiences.

The nurses, as a natural course of action, sought alternative sources of social support and in the circumstances went for external sources of social support. The nurses redirected their efforts for both identity search and psycho-social support. The nurses positive reframing responses

involved whole set of action outcomes that the nurses felt supported their coping within their experiences. The nurses reached out to families back home through social media, engaged with their ethnic and religious groups which provided them with sense of social identity. The nurses engaged in multiple jobs to increase earnings and positively engaged with elderly residents which provide sense of job satisfaction because of the socio-cultural sentiments which the nurses attach to their relationship with supporting the residents.

Consequently, the nurses self-renegotiated their earlier exchange relationships expectations to fit into their present realities. They diverted their goals of greater relational attachment to those of transactional negotiation of their engagement and expectations of material rewards at work. The findings revealed the nurses' reflections on their obligations achieve their personal and family financial responsibilities. As a result, the nurses refocused and re-engaged in multiple employments to earn additional income. The nurses' experiences became a reason for them to revisit their pre-migration intentions of return migration with a fresh sense of purpose. The basis of this was the nurses' consideration of their sense of personal pride and self-esteem. The nurses reported responsibilities requiring material and economic resources and, therefore, they factored in the economic consequences of leaving their jobs and returning to their home countries. The nurses redirected focus into consolidating their stay in the UK through efforts towards earning citizenship statuses as compensatory. This subjective renegotiation of exchange expectations replicates previous research findings on expectations and return migration. Fig (8.2) below shows the nurses' processes of cognitive evaluation and perceptions of experiences at work in the United Kingdom. In the first step, the researcher inductively considered the nurses' cognitive evaluations of their organisational work methods and interactions. The nurses' evaluations of their experiences produced outcomes with consequences for their behaviour and subsequent strategies to cope. The outcomes and consequences as identified in the descriptive themes were clustered to produce the superordinate themes of process defects and trust issues, well-being and organisational commitment and positive reframing. The nurses' positive reframing responses involved action outcomes that the nurses felt supported their coping within their experiences. These included their reaching out to families back home through social media, engaging with their ethnic and religious groups which provided them with social identity platforms, engaging in multiple jobs to increase earnings and engaging with elderly residents to enhance their job satisfaction.

West African MNs on expectations and experiences

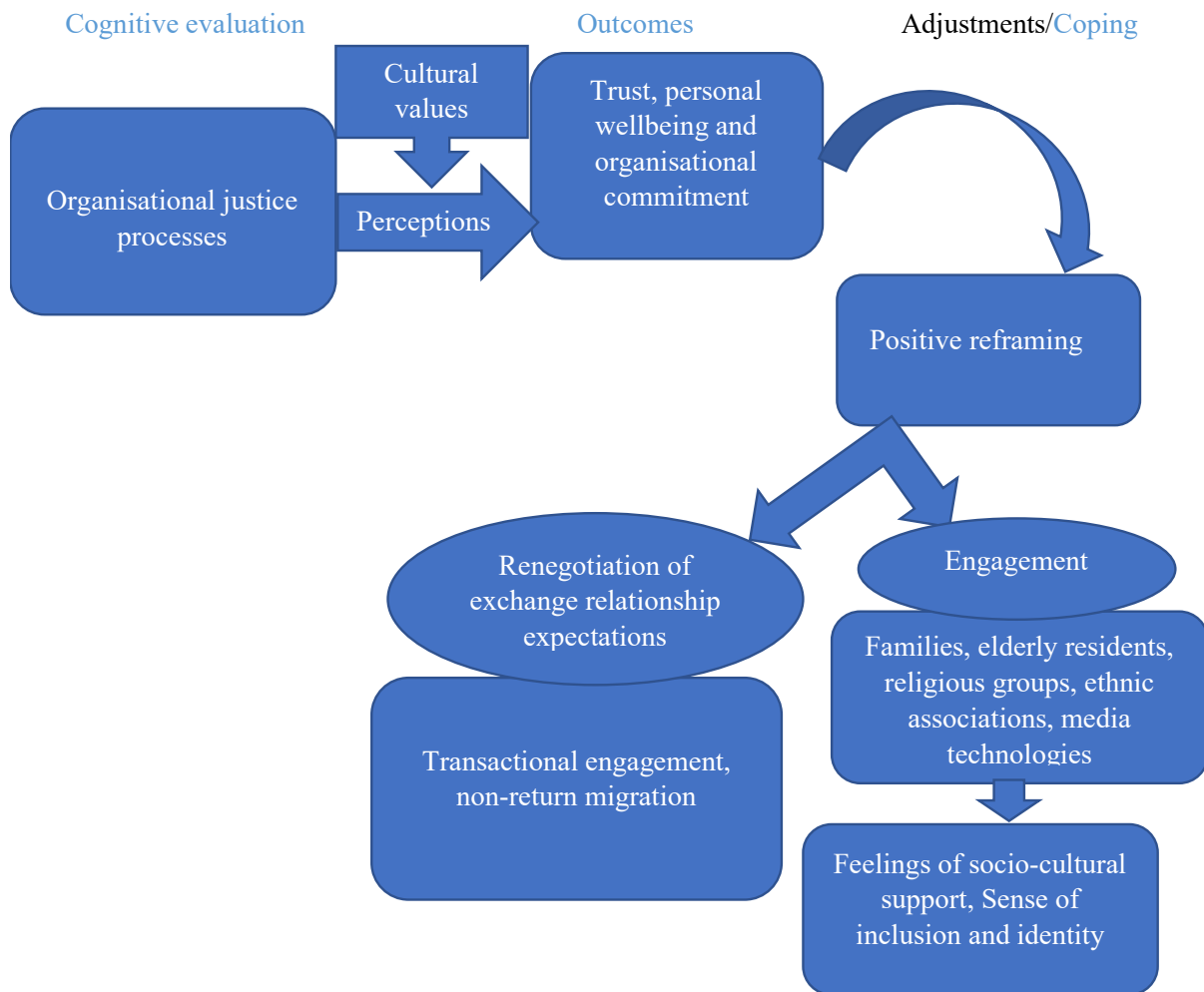


Fig 8.1 The process of the nurses' evaluation of experiences, outcomes and adopted adjustments/coping

Chapter 9: Discussion

This research had the following overarching objectives: *To extend understanding of the expectations and experiences of West African migrant nurses in the United Kingdom; to offer insight into the emotional and behavioural responses of West African migrant nurses on their perceptions of experiences at work in the United Kingdom.* In the context of the above objectives, the researcher explored and answered the following research questions: 1) *What reasons and expectations do West African nurses use to explain their reasons for migrating to the UK?* (2) *How might cultural conceptions explain West African migrant nurses' perceptions of experiences at work in the United Kingdom?* (3) *How do West African migrant nurses manage conflicts between their expectations and experiences?* The research involved a sample of migrant nurses from the society of West Africa. The hermeneutics dimension of the phenomenological approach provided the basis for the researcher to offer insights and deeper understanding on the nurses' thoughts and emotions (Smith and Osborn, 2003) of expectations and lived experiences at work in the United Kingdom through reflective interpretative processes.

The following discussion contains a summary of the main findings in relation to the research questions: a discussion of how the findings relate to previous literature and what they add to our deeper understanding of the West African migrant nurses' experiences at work in the United Kingdom, a discussion of the limitations of the research from both studies; and analysis of the findings in relation to any practical implications and reasoned conclusions about the contributions of the research.

Previous studies, both qualitative and quantitative (Aboderin, 2007; Alexis, Vydelingum, and Robbins, 2007; Allan, and Larsen, 2003; Likupe, and Archibong, 2013; O'Brien, and Ackroyd, 2012; Withers and Snowball, 2003) have reported the negative experiences of migrant nurses in the United Kingdom. The present research took the inquiry further to evolve a deeper understanding of these experiences, in the context of the working lives of West African migrant nurses in the United Kingdom. In doing that, the researcher carried out an initial study (Study One) to answer research question 1) *What reasons and expectations do West African nurses use to explain their reasons for migrating to the UK?* The primary aim of carrying out Study One was to establish basic issues that might influence the nurses' expectations at work.

The information about pre-migration expectations from Study One enabled a better understanding of the nurses' evaluations of their experiences in Study Two which drew on insights from exchange relationship theories to offer focus and process explanations on how the nurses' expectations might relate to their perceptions of their experiences and relationships at work. The initial study is also made knowledge contributions on the migration of West African migrant nurses. Few studies have mentioned the increasing number of West African healthcare professionals, including nurses to the United Kingdom and the United States of America. (Aiken, Buchan, Sochalski, Nichols, and Powell, 2004; Kent, 2007; Thomas, 2011).

9.1 Study One: Building expectations

In the following section of the research, the researcher recaps the findings of Study One to align both studies and provide a complete understanding of the research design and findings. The reasons for the nurses' migration were more complex and multifaceted than those in classical migration theory, revealing anticipations for professional and personal development and achievement as well as better pay conditions.

Study One produced four themes describing the expectations that led West African migrant nurses to the United Kingdom. These fundamental reasons included: **aspirations to improve on skills and knowledge, aspirations for a safe working environment, aspirations to and sustain families' economies and financial needs, and aspirations to enhance personal and family social prestige.** The findings from Study One offered explanations that were anchored on the nurses' expectations of obtaining essential values from both intrinsic and extrinsic (Botsford, 2009; Hazell, 2010) outcomes of migration that they hope will guarantee them job satisfaction and overall wellbeing (Hazell, 2010) in the United Kingdom.

9.1.1 Dimensions of the nurses' expectations and evaluation of experiences

The findings from Study One suggested varied reasons for West African migrant nurses' migration to the United Kingdom. While there have been mixed findings from previous research (Yates, 2010; Alan and Larson, 2003) on the reasons for African health care professionals' migration to western countries, including the UK, economic reasons of economics have dominated the literature on migrants from developing countries, including West Africa. (Massey and Espinosa, 1997; Castle and Miller, 1998; Todaro and Maruszko, 1987; Borjas, 1999). However, in the current study, it was found that West African migrant nurses in the United Kingdom, who are all voluntary migrants, adduced various reasons in their explanations of their decision to migrate to the United Kingdom. Study One, as part of the current research evolves new insights and adds to our understanding of "unmet expectations" identified (Withers and Snowball, 2003) as contributing to the negative experiences of migrant nurses in the UK. The present research therefore adds to knowledge on expectations of migrant nurses in the UK. Additionally, the current research findings generated insights on new issues on migration of professionals from developing regions to western countries.

The West African nurses in the current research, shared, amongst other reasons, for migrating to the UK, the desire to enhance their knowledge and skills using diverse, quality opportunities in the United Kingdom, not only for immediate gains but also for their future careers. An additional reason found to have informed the nurses' migration and expectations included the aspiration to work in safe and conducive work environments. They reported hostile work environments characterised by harassment and non-payment of their salaries in their home countries. The current finding is consistent with previous research by Cordes and Dougherty (1993) and Firth and Britton (1989) that suggest that employees with hostile work experiences are more likely to leave their jobs and organisations. .

West African migrant nurses whose careers depend on continuous training to keep updated in their vocations, considered a conducive work environment with training opportunities, which the United Kingdom offers, as a decision point to migrate. Due to their previous work experiences in their home countries, where, in some cases, training equipment may be inadequate, an opportunity to enhance skills and knowledge in the United Kingdom became a great bargain. While this finding represents a new understanding of African professionals' migration, it is consistent with suggestions that an increase in knowledge and skills in a

professional life enhance job satisfaction and well-being for individual employees as they prepare and expand the scope for their career development opportunities (Salas and Cannon-Bowers, 2001; Warr, 2002).

While the nurses mentioned skills and knowledge as reasons, financial and economic gains formed considered reasons for the migration to the United Kingdom. The nurses' explanations of this reason were informed by the socio-cultural obligations on privileged members of their societies to cater for both their nuclear and extended family members. West African society, being fundamentally a collectivist environment, assigns caring responsibilities automatically to family members who have both material and social access to assume flag bearers' support of their families, nuclear and extended. One fundamental implication of the nurses' financial and economic reasons for migration was the socio-economic expectation that as women professionals their economic and financial value was a strong variable which could predict positively on their marriage expectations. In societies, where marriage is considered a determinant in the social construction of the identity of females the males respect and tend to propose marriages to women who can bring material support or offer them opportunities to travel out of their countries. West African migrant nurses formed their expectations at work in the United Kingdom in the context of the above reasons for their migration. Simon and George (2013) suggest that employees evolve expectations that form the basis for a dynamic revaluation of their exchange relationship over time. These expectations occur in phases, including pre-employment perceptions, early socialisation, later experiences, and evaluation. The nurses' formation of expectations was based on their personal and professional schemas (Ken and Vico, 2015), which then inform their cognitive evaluation (Abu Dole and Hammou, 2015) of experiences at work.

9.2 Study Two (RQs2 and 3)

In Study Two of the research, the researcher explored two of the remaining research questions *(2) How might cultural conceptions explain West African migrant nurses' perceptions of their experiences at work in the United Kingdom and (3) How do West African migrant nurses manage conflicts between their expectations and experiences.*

According to theories (Meyer and Allen, 1991; Salancik and Pfeffer, 1978), perception is a cognitive concept associated with retrogressive evaluations of assumptions and expectations of current experiences. Subjective perceptions and evaluations of events, processes and actions are argued to be commonplace in contemporary organisations (Bratton, Sawchuk, Forshaw, Callinan and Corbett, 2010). Sense making are commonly applied to interpersonal relationships and interactions as well as organisational group interaction (Cennamo and Gardner, 2008), especially as groups and individuals assign different interpretations and meanings to events and actions.

Subjective perceptions, interpretations and meaning given may not represent an objective account of reality because this could be socially constructed or the outcome of existing schema or knowledge. The subjectivity of outcomes of perception, therefore, relates to how human judgments are made amid different possible realities (Bratton, Sawchuk, Forshaw, Callinan and Corbett, 2010). In the context of the present research, West African migrant nurses' experiences were examined as qualitative and subjective cognitive processes, involving the nurses' understanding, interpretation and responses to their organisational environments involving the actions of their managers and colleagues (Maitlis and Christianson, 2014; Weick, Sutcliffe and Obstfeld, 2005).

Theories and research (Trompenaars and Hampden-Turner, 2014; Black and Gergesene, 1999; Erez and Earley, 1993; Kastanakis and Voyer, 2014; Lowe and Schellenberg, 2002 Markus and Kitayama, 2010; Fischer and Smith, 2006; Markus and Kitayama, 1991; Thomas, Kevin and Ravlin, 2003) have documented how schemas as cultures built-in blocks of values can determine and influence perceptions of events and actions in multicultural group environments. Paswan and Ganesh (2005) as well as Loh, Restubog and Zagenczyk (2010) have also reported patterns and varying outcomes in migrants' cultural adjustments at their destination countries. The current research findings revealed that West African migrant nurses' cultural values influenced their perceptions of events and how they attached meanings to their interpersonal relationships at work in the UK. These values reflected in the nurses' perceptions of organisational processes and interpersonal relationships at work which were consistent with previous suggestions (Markus and Kitayama, 1991; Mor Barak, 2005; Thomas and Ely, 1996; Thomas, Kevin and Ravlin, 2003; Thompson and Rosch, 1999; Ronen and Shenkar, 1985) that cultural values could be influential in employees making sense of processes and issues in the organisation. These were also reflected in the nurses' evaluations of experiences at work as well as in their responses and coping within those experiences.

According to Ferris, Russ, and Fandt (1989), employees' observations of their relationships and the general organisational dynamics provide them with a clear understanding of organisational processes and their outcomes. West African migrant nurses consciously engaged in the evaluation of their managers' relationship with themselves and other members of staff and this provided clues to the nurses' make sense of their organisational environment. The outcome of this research suggests that the participants' subjective perceptions, consistent with literature, (Kickul, 2001) led to their feelings of concerns regarding organisational justice processes at their workplaces.

The researcher acknowledged the position of Smith *et al.* (1999) that there is generally a thin line between the analysis and the discussion sections of interpretative phenomenological research. In this thesis, the contents of analysis in this research are incorporated into the discussion to allow further interpretation of the findings in the light of existing theory and research. Study Two findings produced six superordinate thematic themes for both research questions two and three. The themes are **power and leadership, family life at work, caution**

in management of conflicts, process defect and trust issues, well-being and organisational commitment, and positive reframing. Fig 9.1 below shows the various descriptive themes that were clustered to produce the six superordinate themes for research Questions 2 and 3.

Fig 9.1 Descriptive themes clustered into six superordinate themes.

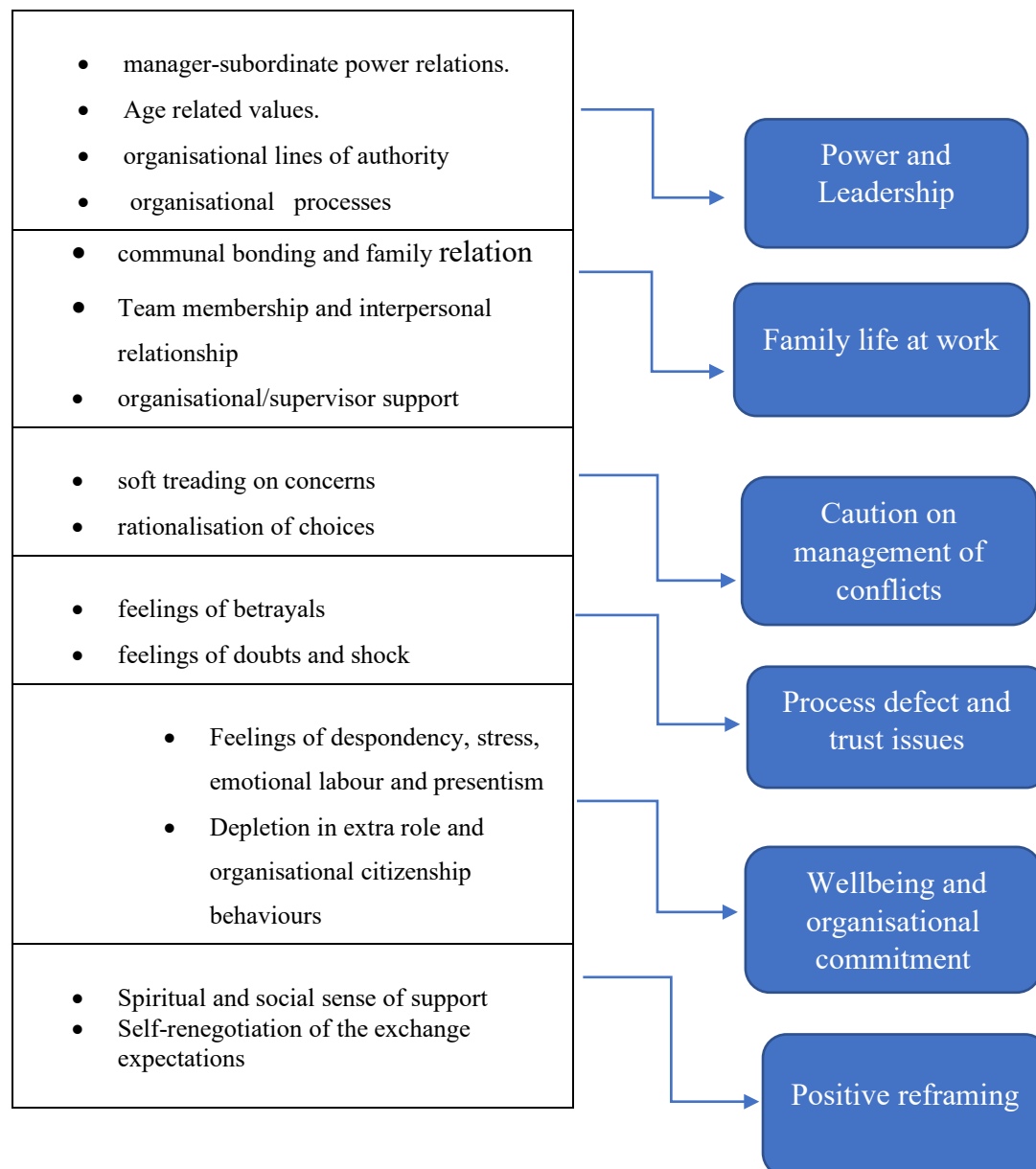


Fig 9.1 Descriptive themes clustered into six superordinate themes

9.2.1 Superordinate Theme One: Power and Leadership

Research Question Two explored how culture might explain West African migrant nurses' perceptions of their experiences at work in the United Kingdom. The "power and leadership" theme explains the nurses' attachment of values to the bases and positions of power and, in their perceptions, how absence of their managers' demonstration of clear and differentiated use of power and authority created a dysfunctional environment for both processes and interactions. The nurses' accounts revealed the outcomes of their evaluation of their managers' leadership approaches contrary to their expectations and consistent with their perceived acceptable value practices of their high-power distance cultures. The findings reflected in this theme is consistent with theoretical suggestion (Inkeles, 1997) that cultural value differences can have influences on employees' perceptions of organisational processes and behaviours as in the dynamics of use of power and resolution of conflicts.

Leadership "is the processes wherein an individual member of a group or organisation influences the interpretation of events, the choice of objectives and strategies, the organisation of work activities, the motivation of people to achieve the objectives, the maintenance of cooperative relationships, the developments of skills and confidence by members, and the enlistments of support and cooperation from people outside the group or organisation." (Yukl, 2006:5). Leadership as a concept of management, is among other issues, a matter of power relations which not only shapes organisational processes but also influences on the thoughts and actions of organisational members (Zaleznik, 1998).

In the present research, while the findings suggest that the nurses, consistent with their high-power distance cultures expected functional power gaps to exist in their managers'-subordinates' formal relationships, the real perceived dynamics of interactions and relationships at work created deeper impact of meanings for the nurses. The nurses had expectations of formal management norms of effective guidance, direction, benevolence, and support (Hofstede, 1991; 2011; Lustig and Koester, 2013). However, the nurses' accounts revealed their feelings of concern on their native British managers' power positions and how these are used to influence group dynamics at work. With regards to the nurses' evaluation of their managers' power and authority relations with themselves and their carer colleagues, the nurses' felt their managers' delayed approach towards their carer colleagues was inconsistent to their expectations. The nurses' perceptions of their managers and junior staff (white carers)

engaging in highly informal rather than formal interactions while at work, such as going out together for cigarettes and the carers rather frequent presence in their managers' offices for hours during working hours, presented as influencing environment of dominance and exclusion.

While the managers' perceived delayed interactions with the nurses' carer colleagues could be reflective of the United Kingdom's ascribed high masculinity-femininity and low power distance cultures, the nurses' perceptions of their managers rather informal closeness and interactions made the nurses feel excluded as a result. The nurses' accounts suggest their feelings of being outsiders, which reflects a divided social environment. The nurses' deep concerns on the delayed relationships and interactions of the managers and carer colleagues reflected consistency with an emergence of high leader member exchange differentiation and creation of ingroup/outgroup social environment. The nurses' sensitivities on these interactions and their perceived emergence of ingroup/outgroup dynamics created tensed environments for them. Dalton and Chrobot-Mason (2007) argue that LMX differentiation which creates workplace in groups and out groups could be outcome of differences in ethnicity or social groups, especially when the manager shares same identity with a particular group. The nurses in these circumstances perceive themselves as the out-group within the social identity power and relevance struggles.

With demographic similarity found to create dominant group identities and encourage exclusionary tendencies and pressures on a minority group (Mehra, Kilduff and Brass, 1998), the nurses' feelings of organisational ostracization as a consequent, increased their perceptions of dysfunctional organisational justice processes in allocation of resources and patronages (Uhl-Bien, Graen and Scandura, 2000). Similarly, it created in them, senses of distrust due to perceived inequality practices (Jehn, 1995). With increase in LMX differentiation (Essed, 1991; Hodson, Roscigno and Lopez, 2006; Stephan and Stephan, 1985) comes a corresponding increase in intergroup prejudices, systematic inter-anxiety, suspicions, and groups possible avoidance of intergroup interactions, information processing biases and continuous threats to self-esteem. The nurses' articulations and perceptions of the circumstances of interactions and relationships at work predicted their fundamental feelings of discrimination and inequity, consistent with arguments (Williams et al, 2003) of the tendency for the dominant group unequal treatment of the subordinate group characteristic of such social group environments.

Previous research (Likupe, 2006; Shields and Price, 2002; Smith, Allan, Henry, Larsen, and Mackintosh, 2006) found that positional networking and lack of transparency in the work processes impacted on how matters of training and other opportunities at work were distributed in the experiences of migrants. The fundamentals of such perceptions, with the current findings could be traced to the norms and practices of management through the creation of high LMX differentiation at work. The nurses felt that the creation of the “we versus them” relationships placed them at a disadvantage because of their fears that the junior carers were consciously using their informal delayed relationships with their managers to gain valued advantages and sustain social categorisation at work (Anderson, 1990). This led to the nurses’ further perceptions of a lack of transparent organisational management processes within an open organisational framework. This situation, according to findings, further created doubts in the minds of the nurses about fairness and effective management of equity applications in decisions, resource allocations and patronage.

Furthermore, the nurses’ subjective perceptions of their managers’ delayed interactions with the carers of same demographic similarity was perceived to create weak ties for the carers positive attachment to influence access to the managers’ considerations on resource allocation and personal development opportunities (Ibarra, 1995; Sagas and Cunningham, 2005). With increased LMX differentiation, group power struggles for the intents and purposes of achieving measures of control over access and privileges, becomes a common occurrence in multi-group organisations (Brown, 2000; Buttigieg, Bryant, Hanley, and Liu, 2011). The nurses therefore perceived potential undue advantage on work processes and patronages to the native British carers and to the disadvantage of the nurses. Workplace relationships and use of power are contemporary organisational issues that are instrumental in organisational members gaining advantages over critical resources at work, including access to decision making (Lewis and Zibarras, 2013).

Fundamentally, the nurses’ feelings of frustration and disappointments deepened with their perceptions of their losses of relational engagement with their managers due to the perceived increase on the LMX differentiation in favour of the carers. The nurses had expected to achieve on their own, organisational socialisation and engagement through the managers. While globalisation may be removing differences in leadership practices across societies, researchers, and theorists Zagorsek, Jaklic, and Stough (2004), Hofstede (2001) and Triandis (1995) argue

that strong variances exist across societies in cultural value tolerances and acceptances, especially in organisational leadership practices. The nurses perceived that their managers' style of management seemed overtly delayed interactions and relationships with the native white carers undermine their (migrant nurses') effective exercise of control and leadership authorities as nurses'-in-charge of their shifts. The findings suggest that the nurses, culturally inclined to conventional senses of loyalty to those in authority in recognition and acceptance of paternalistic power relations (Hofstede, 1984; Schwartz, 1992), had expected this form of work relationships with managers. This expectation is consistent with the nurses' value perceptions of social hierarchy-based role relationships and seniority at the workplace in high power distance and collectivist cultures (Pearce, 2001). The nurses had also anticipated to foster formal paternalistic relationships with identified key members of the organisation, in this case, their managers who represent symbols of power and authority for support for them.

In the present situation, the nurses felt that the informal relationships between the carers and the managers affected the fostering of this relationship with their managers. For instance, the nurses' perception that the managers send messages across to them through the carers makes them feel that they are under the authority of both their managers and of their junior carer colleagues. Drawing on their cultural backgrounds, the nurses feel that any source of organisational communication suggests a source of power control that also represents organisational authority. The power and authority distribution of West Africa, Hofstede (2011) suggests, supports a high-power distance environment, which means that the people accept a hierarchical order.

While the nurses feel that organisational leaders should command benevolent control, they equally expect that age bestows seniority, which on its own deserves naturally occurring respect at work. So, the nurses anticipated two aspects of domains of authority and respect, the naturally occurring seniority in age and organisational seniority. The nurses' responses suggest perceptions of generation gaps as possible attributes of respect that, in their interactions, were not being recognised by either their managers or their young white carers. While age-related values and respect in an organisation may not represent universal acceptability because of the variations in cultural perceptions of what constitutes respect (Rogers and Lee-Wong, 2003; Thorne, Harris, Mahoney, Con and McGuinness, 2004), the present research findings on the expectations of the West African migrant nurses at work is

consistent with the findings (Giles, Dailey, Sarkar and Makoni, 2007) that communication of respect at the workplace could be both age- and status-dependent, especially in considerations of respect for the elderly.

The nurses' expectations of respect were not only regarding their perceived seniority as nurses-in-charge but also regarding their age-related values of being older than the white junior carers. Such expectations, which are synonymous with their West African cultural value beliefs of the relationship between age and wisdom bestowed by supernatural beings, hence the sense that values of respect to an older person is sacrosanct even at workplaces (Darley and Blankson, 2008; Nyagua and Harris, 2008). This belief appear to further explain the nurses' considerations of their positive relationships and care of the elderly residents which offered them intrinsic satisfaction and sense of socio-cultural wellbeing. The nurses' perceptions that the young white carer members of the team ignored them represented to the nurses a show of disrespect which they felt their managers should recognise and address but rather, in their perception, the managers continued to direct instructions through the young carers to the nurses. In their expectations to advance in their positions as supervisors at work, being the nurses-in-charge, the nurses felt that for them to manage their shifts, the white carers should be made to understand the chain of instructions to show them respect. The perceived processes of communication were in complete contrast to the nurses' expectations.

The apparent lack of a normal flow of communication within the proper chain increased the nurses' concerns about their lack of involvement in the organisational processes and, by extension, a lack of trust between the nurses and the managers. The nurses' perception that their managers do not relate to them appropriately was considered a relational issue that affects their relationships with other colleagues, especially the white carers. The nurses' expectations, which are associated with their high-power distance, are that the centralisation of management structures, should be a basic operative norm (Rodrigues and Blumberg, 2000) in which they feel secure and reassured of the processes.

The nurses' accounts revealed their intolerance of their managers' use of power and styles of leadership which informed their concerns about achieving their organisational socialisation objectives because of their perceived inability to develop and sustain relational contacts with their managers. High leader-member exchange is a functional concept which has been argued (Wayne, Liden, Kraimer and Graf, 1999) to foster and advance employee opportunities at work

through access to information and positive task assignments (Graen and Cashina, 1975), the leader member exchange construct which relates to relationships at the group levels could inform tensed organisational social environment. However, the nurses believe that, with a strong trusting relationship with their managers, their access and socialisation in the organisation could be possible. The nurses' numerous and constant emphasis on words such as "boss, " "manager, " and "in-charge" reflects their cognitive schemas (Werth, Markel, and Foster, 2006) on the significance of achieving a high leader-member relationship.

The current research finding is consistent with Costigan, Instinga and Berman (2011) findings that trust is fundamental in employees initiating and sustaining high leader-member relationships in high power distance cultures. To the West African nurses, initiating such affect-based trust-building relationships comes naturally because of their collectivist cultural background, where personal relationships and social networking are significantly recognised (Sherman, Mayer, and Davies, 2007). The nurses, consistent with their cultural notions, looked up to their managers, as the significant power and authority holders, to guarantee their own positions and reassure them of fair and protective support for their effective organisational socialisation. In their beliefs, the nurses consider it more reassuring that their managers assume quasi-patriarchal roles of consistent reassurances, as within families back in their home countries. This finding of the nurses' expectations on their managers as "protective shields" is consistent with the theory (Lustig and Koester, 2013) which suggest that the impact of high-power distant cultures is common in their organisational management practices and environments.

Within the context and understanding that employees use their managers actions and relationships to make sense of organisational processes (Eisenberger, Huntington, Hutchinson, and Sowa, 1986; Levinson, 1965), the West African migrant nurses demonstrated expectations of high relational exchange with their managers. The findings suggest that as a group from a high-power distance culture, the nurses exhibited fears and concerns about the similarity attraction-based leader member exchange relationship that could develop between their managers and junior carer colleagues. Furthermore, for a group that has an attraction to relational exchanges expectations given their high-power distance cultures, the nurses perceptions that their managers are not as protective as expected increased their senses of vulnerability at work. While the nurses expect functional relational exchanges with their

managers that can make them feel wanted and supported, they felt concerned that their managers' lateral leadership styles and relationships with the carers seemed not to guarantee those expectations, hence their perceived loss of trusting platforms to engage, interact and succeed at work.

9.2.2 Superordinate Theme Two: Family life at work

The findings based on this theme suggest the nurses' expectations of the work environment to project bonding in relation to care, concern, and general socio-emotional support for organisational members as extensions of their families. The nurses' perceptions of their relationships with managers and colleagues reflect the cultural sense of workplaces as extensions of the family network which is a cultural characteristic of West Africa (Aju and Beddewela, 2020; Metz, 2007; Nussbaum, 2003). The present research findings reflects the West African traditional beliefs that workplaces are extensions of families rather than competing social settings.

The nurses, coming from backgrounds that support extensions of family life at work not only perceived their workplaces as part of their families but also relied on functional high exchange relationships with their managers as protective figure heads, to effectively place them within the in-group of their organisations (Bass and Bass, 2008). The findings suggest that the nurses' desires and expectations for engagement, acceptance, solidarity, and protection were fundamentals for negotiating their socialisation at work. The findings in current research revealed that the nurses, consistent with West African collectivist cultures, considered membership of the in-group of their organisation as consistent with their membership of their families, hence the notion of collective reciprocity (Shizha, 2016) which makes for sanctity and harmonious relations (Hui and Triandis, 1986). The nurses account revealed their frustrations with the realisation that their colleagues at work and outside of work did not share in this understanding, causing them to readjust their expectations at work.

In the context of their relations and socialisation, West African family-oriented norms and values are elastic because they promote extensions of family relationships, hence the concept of extended family systems (Bassey & Oshita, 2010). This socio-cultural orientation extends

to any form of social organisation the people find themselves in, including work organisations. West African society and management practices are symbiotic, hence the nurses' expectations of relationships not only with their managers but also with carers and other colleagues. The management of a typical Africa formal organisation is drawn to articulate practices and policies that are seen to support a collective sense of community (Iwowo, 2015). It came, therefore, as a cultural shock to most of the nurses to realise the extent of personal space in the United Kingdom, which does not support in its real sense, communal collaborations. African traditional values support group and communal solidarity (Guerin, Diiriye and Yates, 2004; Whittaker, Hardy, Lewis, and Buchan, 2005) with the emphasis on social support and responsibility rather than individualistic existence which is operative in high individualistic cultures such as the United Kingdom.

The nurses high power distance and patriarchal societies identify heads whose responsibility is to encourage group loyalty for which members are obliged to comply in the spirit of friendship and brotherhood. In contrast, the nurses' evaluations of the actions and behaviours of both their managers and other white colleagues led them to believe their colleagues were exclusive and non-receptive towards them. From a society that promotes the extension of family values into work organisations, the nurses' data suggest that their initial expectations that friendships would be cultivated easily with colleagues and transcend outside of work, were rebuffed and this became like a shock to many of them. The close social framework in African traditional ways of life (Triandis, 1995) encourages individuals to feel an integral part of the in-group to enhance group goals. Consequently, the nurses had expectations that as members of their work group, their managers should not only support them but also take into consideration their pastoral needs involving families and other personal issues (Matondo, 2012).

In the context of the nurses' socio-cultural background, which defines a thin line between the private life of the individual members of the society and work life (Ubeku, 1983), the nurses had expected that their managers and colleagues would show more concerns for their personal and family lives and welfare hence their feelings of disappointments in the absence of this engagement with their managers at work. The gaps created between the nurses' expectations and experiences further led to the nurses' loss of faith in both management and organisational processes.

The nurses interpreted the lack of engagement on family issues from colleagues and managers as a lack of both organisational and social support. Further, their perceptions that they were not considered part of the in-group in their organisations made them feel a sense of loss of identity given their West African collectivist culture that encourages group cohesion and existence. The nurses felt lost in an environment which they perceived to be highly individualistic with little or no platforms for a community sense of interactions. In the circumstances where these seemed to exist, the activities did not conform to what the nurses were used to. For instance, for the greater part of their work hours, activities that seemed to promote communal social interactions could be in the coffee room or smoking shelters, areas that are popular with their British colleagues but not culturally attuned to the nurses' lifestyles. The nurses expected greater bonding but with their manager and colleagues being unresponsive to their family-related affairs since some of these are considered personal issues, the nurses felt lonely and unsupported.

In the context of the research question 2 which examined how the nurses' cultural conceptions might explain their perceptions of experiences at work, the nurses' accounts provided insights into the value they placed on their expectations of family-oriented work environments, consistent with collectivistic cultures. Contrary to their expectations, the nurses felt disappointed with the negative outcomes of their expectations.

9.2.3 Superordinate theme three: Caution in management of conflicts

The nurses' accounts revealed a strong desire to avoid interpersonal conflicts at work. The nurse's expressions indicated their unwillingness to face or cope with what they fear could lead to a direct confrontation. This approach can be explained by cultures of collectivism and femininity (Hofstede, 1991) which can cause a desire for harmony and discourages overt conflict and confrontations. The nurses' overall approach of non-visible reactions and no attempts to address issues of concern with their managers, for fear of perceived reprimand, could also reflect the influence of the high uncertainty avoidance culture that Hofstede argued was characteristic of West Africa (Hofstede, 1991).

The use of grievance procedures and other employee voice mechanisms in organisations encourages communication of opinions and expressions of concern utilised appropriately. These processes, according to LePine and Van Dyne (2001) and Van Dyne, Ang, and Botero (2003) increase employee organisational self-esteem, initiatives, and innovations because conflict issues and concerns are managed and improved, leading to positive changes and positive organisational outcomes. In expressing their views, employees use voice behaviours as means to mention and manage dissatisfaction instead of leaving it unattended (Spencer 1986).

However, findings from current research revealed that while the nurses had experiences of concerning incidents and interpersonal conflicts at work, they opted to adopt the conflict avoidance approach, preferring to allow issues to go away as they occurred. The findings revealed that the nurses, in some instances, had expected their manager, as a higher authority in their organisation, to take responsibility for observing and intervening on their behalf. In adopting this approach as a face-saving measure to maintain social harmony (Black and Mendelhall, 1993; Gabrielidis, Stephan, Ybarra, Pearson, and Villareal, 1997), the nurses' responses further reflected actions which are consistent with their high collectivist and uncertainty avoidance cultures (Hofstede, 2011) which promote avoidance and third-party mediation in conflict issues. The nurses had felt that making complaints at work would isolate them much more than it would include them, hence their adopted approach of managing interpersonal and organisational conflicts with extreme caution.

The research findings suggest that, in the absence of the expected support from their managers, the nurses' responses to concerns or actions that would ordinarily be questioned were let to go. The proximal explanation of the nurses' pacifist responses was to experiences of personal emotional conflicts that might accompany being put in the spotlight either to defend or make complaints. West Africa scores high on uncertainty avoidance in which interpersonal conflicts are minimised because of perceived risks (Clark, 1990). Therefore, cultural values can explain the nurses' adherence to actions of mitigation to avoid incidents and actions that might be interpreted as deviant which could lead to unhealthy changes and disrupt existing relationships (Kale, and Barnes, 1992). With a great sense of the emotional need for adopting predictable approaches that are seen to guarantee the security of operations and actions, West African nurses feel more comfortable coping on their own with issues of concern they experience at

work. In their socio-cultural background, the avoidance of direct confrontations saves face and sustains their relationship with others in their interactive cycles or environments such as their workplaces (Triandis, 1994). From the findings, it appears that West African nurses' approaches to getting over conflicts at work define compromising schemas of guided approaches to conflict resolutions. Whilst the cultural background of the nurses probably predisposed them to avoid confrontation, their interviews also suggested that they thought confrontation would not work and might make the issue worse because of the intergroup discrimination in the nursing homes. The nurses referred to not expecting to get a good response from their managers and expecting the managers to take the side of the white carers against them. They also doubted the fairness of management actions. So, potentially, a non-confrontational approach might just be the only rational action in the circumstances.

Unfortunately, the nurses' inaction in terms of not following up on concerns, and their adoption of the non-voice, avoidance coping strategy, impacted on their socialisation and access to relevant organisational resources. While the nurses' non-confrontational approach avoided overt conflict at work, it did not make the issues go away; they continued to impact on their emotions at work. This caused the nurses to adopt the further behavioural responses of self-withdrawal. The findings revealed that the nurses minimised their organisational socialisation, not sharing or engaging with their managers and colleagues alike. The nurses' behavioural responses and their perceived absence of a high leader member exchange relationship with their managers created further disconnect between the nurses and their organisation. This situation did not work in favour of the nurses.

9.2.4 Superordinate theme four: Process defect and trust issues

Research Question Three examined how West African migrant nurses managed conflicts between their expectations and experiences. The nurses' expectations, which formed their reasons for migration to the United Kingdom, were summed up in their aims of obtaining essential values from both intrinsic and extrinsic rewards from their migration and work (Hazell, 2010). Based on their reasons for migration to the United Kingdom which included safe work environment, enhancement of skills and knowledge, personal and social prestige and

to meet financial and economic responsibilities at home, the findings revealed that the nurses were able to reflect on their experiences in relation to their expectations.

The nurses' expectations of employment in the UK, as in the psychological contract which as mental model of implicit expectations (Abu Dole and Hammou, 2015) evolved in phases (Simon and George, 2013). The nurses accounts revealed that they used the organisational justice framework to measure methods and interactions (Anderson, 1996) at work. According to Bies and Moag (1986) and Lewis and Zibarras (2013) The organisational justice system make it easy to make a judgment of the allocation of resources and fairness of the processes as well as the nature of interpersonal relationships (Bies and Moag, 1986; Lewis and Zibarras, 2013) at work. However, research (Thomas, Au, and Ravlin, 2003; Lind, Tyler, and Huo, 1997) argue that cultural values can influence the perception and evaluation of experiences of the psychological contract breach as well as responses to it.

In relation to the nurses' expectations of safe a working environment and the opportunity to enhance their skills and knowledge, the findings of the research revealed the nurses' identification with the power positions of their managers and their hopes to achieve effective organisational socialisation through quality relationships with their managers. The nurses' expectations of paternalistic support from the manager ranked at the top of their expectations of a safe, enduring, and respectable work environment that would guarantee them access to organisational resources and opportunities. The findings suggest that the nurses, consistent with their high-power distance and uncertainty avoidance cultures, expected their managers to assume the role of the "benevolent autocrat" which would encourage their relational attachment to their managers. The nurses' collectivist and high-power distance cultural orientations led them to expect a genuine show of concern (Konrad and Deckop, 2001) by their managers.

This finding, while consistent with previous research (Eaton and Louw, 2000) suggestions that individuals from collectivistic cultures associate themselves more with their social groupings, also highlighted the nurses' attachment to their West African traditional values that emphasise group and communal affiliations and solidarity (Guerin, Diiriye and Yates, 2004; Whittaker, Hardy, Lewis, and Buchan, 2005). However, in the nurses' perceptions of the absence of this managerial presence and oversight, the nurses felt that their managers were not receptive, relational and supportive. The nurses' disappointment is consistent with previous research (Aju

and Beddewela, 2020), which suggest that managing relations at work involving Africans require the encouragement of the traditional relational exchanges between management and subordinates, absence of which has led to consequential management failures and dysfunctional relationships between the “westernised” manager and traditional employees.

Dansereau, Graen and Haga (1975) also suggest that high positive exchange relationships between managers and employees is crucial because they predict positive organisational outcomes. Exchange relations can develop through various ways, such as the natural inclination based on the similarity-attraction paradigm (Kacmar, Harris, Carlson and Zivnuska, 2009) or through a trust building process. The nurses’ accounts suggested that they had anticipated an affect-based experience of trust building as that leads to more positive leader-member relationships in high power distance countries (Costigan, Instinga and Berman, 2011).

The finding of the nurses’ expectations of achieving a high quality leader-member relationship through a paternalistic trust building approach is consistent with previous research (Doney et al, 1994; Van der Vegt et al, 2005; Kale and Barnes, 1992) which argued that people in high power distance societies view others as a threat and show less inclination to trust them are less inclined to trust others in high power distance cultures and Spector and Jones (2004) found that communication gaps in hierarchical power relationships in high power distance cultures serve to increase feelings of distrust. Consequently, the managers’ lack of expression of concern and consideration for the nurses and their families could increase the nurses’ feelings of distrust.

A trust-based relational exchange enhances interactions, care, and concern for well-being (Ronald, Mankind, and Lawrence, 2007; Burke, Sims, Lazzara and Salas, 2007; Deconinck, 2010; Whitener, 1997) which has also been argued to impact on employee job satisfaction and performance. In the present research, the finding that the nurses’ anticipation of a high trust-based relationship was fundamental to their perceptions and evaluation of the organisational justice process as well as the nature of supervisor support can be explained by their high-power distance and collectivist cultures (Gesteland, 1999; Schoorman, Mayer, and Davies, 2007) which promote personal relationships and social networking above any other issue in exchange relations.

In the nurses' perceptions, a high exchange relationship between them and their managers is interpreted as leading to acceptance, collaboration and organisational paternal support and reassurances. The nurses initially expected their organisational socialisation to take place through their relationships with managers, which they hoped would avail them of work information and task support. In this regard, the findings suggest that the nurses had no other means of engaging and exploiting organisational resources, except through a trusting relationship with their managers. Trust as the willingness of one person to be vulnerable to the actions of another (Mayer, Davis and Schoorman, 1995) was found to be the basis on which the nurses expected to ensure their effective socialisation at their workplaces. With a background of high collectivism and uncertainty avoidance, the had intended to engage the trust and confidence of their managers. This may be interpreted as vulnerability, but the nurses felt it was a source of strength.

The nurses' consequent negative perceptions of slack relationships with their managers, therefore, impacted their expectations of the direction and kind of developmental relationships that would exist between them and their managers. The nurses felt the lack of strong, high-quality leader-member exchange relationships had an impact on the kind of feedback and support they get from their managers. Many of the nurses perceived negative feedback from their managers as an indication and demonstration of the lack of managers' trust in their abilities and skills. Even though this may not represent the intention, the conflict in defining intentions is highlighted in this circumstance.

This research found that, in the absence of the nurses' anticipation of trust-based paternalistic relationship relationships with their managers, communication was impacted and any actions, no matter how well intended, were misinterpreted, and assigned negative connotations. Further findings suggest the nurses' perception that their managers would rather seek feedback on their performances from their junior carers than seek their views do not seek their views on issues, creating feelings of mistrust and concerns for the nurses.

The findings suggest that the nurses, developed doubts not only about their relationships with their managers but also about the organisational justice processes in their organisations, such as in their perceptions of lack of organisational support, lack of positive effective feedback, high workloads, lack of respect, intimidation and bullying, and lack of recognition of skills and knowledge. The nurses' belief that their managers discuss their private conversations with

the carers make them feel more withdrawn in discussing personal issues with their managers. In cases where it seemed their managers had allowed some independence for the nurses to manage their tasks, which may be ordinarily be seen as a supportive intervention and recognition of skills which enhances employee psychological empowerment and job satisfaction (Eisenberger, Huntington, Hutchinson and Sowa, 1986; Gist, 1989; Lathan and Trayne, 1989), the nurses perceived these acts as deliberate attempts to put them in the spotlight for criticism with the effect of reduction in their self-esteem.

The findings further suggest that the nurses' perceptions of lack of organisational social support impacted them with feelings of being left out. This caused them to withdraw from mainstream organisational activities as well from active interaction at work. Nevertheless, the nurses chose to be at work rather than at home, enduring the pains of presenteeism and its impact on their emotional labour. In cases of perceived isolation, both Eastburg, Williamson, Gorsuch and Ridley (1994) and Ray and Miller (1991) suggest that these have negative emotional consequences which can lead to behavioural responses, as evidenced in the nurses' behaviour. The finding of the nurses' behavioural responses to their evaluation of their managers behaviour and its impact on their emotions is however in contrast to previous suggestions (Cordes and Dougherty, 1993; Firth and Britton, 1989) of a relationship between employee emotional exhaustion and absenteeism and turnover intentions. In the current research findings, the nurses continued to stay at work with no intention of leaving, nor did they go off work with imaginary complaints of sickness or other reasons. However, the nurses' perceptions had their effects in other ways such as their feelings of a lack of job satisfaction and organisational commitment.

9.2.5 Superordinate theme five: Well-being and organisational commitment

In examining the research question about how the nurses managed conflicts between expectations and experiences, the findings revealed issues concerning the nurses' well-being and level of their organisational commitment. Work environmental stressors such as defective work design and dysfunctional interactions (Spector, Cooper, Sanchez, O'driscoll, and Al, 2001), can lead to psychological and physical strains with an eventual impact on employee being. However, it has been argued that individuals' perceptions of wellbeing can be culture

dependent (Bhagat, Kedia, Crawford, Kaplan, 1990), on the basis of considerations of the independent self, interdependent self, active control, and relationships (Luo, 2006). For instance, while employees in individualist societies may seek independent and personal methods of enhancing their well-being, collectivist societies tend to rely on social relations and affiliations that reflect the interdependent locus of control (Markus and Kitayama, 1998). While the concept of well-being can be understood at the individual level, it can also be considered at the collective level with variables that reflect the interactional perspective (Morgeson and Hofmann, 1999).

In the case of the current research participants, the findings suggest that the nurses' beliefs, reflecting their collectivist and power distance cultures, are more applicable to interdependent relationships which aim to promote harmony at work (Triandis, 1994). It has been noted elsewhere in this thesis that the nurses' relational exchange expectations at work were characteristic of their West African high-power distance cultures which encourage paternalistic and protective actions of managers on subordinates (Hofstede, 1980). The findings of this research revealed the nurses' expectations on their managers to serve as "protective shields" for them at work.

With expectations of organisational socio-emotional support from their managers and colleagues at work, which the nurses believe is fundamental to relational exchange expectations, and an antecedent to positive organisational outcomes (McLean Parks and Schmedemann, 1994), the nurses had hoped to effectively fit into the organisational socialisation process. The findings suggest that the nurses had expected to have a trust based high leader-member exchange relationship with their managers to access necessary work resources and support. For instance, theorists (Hobfoll and Shirom, 2000) suggest that managers' provisions of necessary tools to employees to deal with work environmental stressors which could otherwise impact on their emotional resources, are perceived as a form of organisational support. However, the nurses reported experiences of a high workload, lack of organisational or supervisor support, negative feedback, and lack of concern for their personal and family matters which led them to feel disillusioned. The finding that the nurses' perception of work overload and interpersonal conflicts caused them emotional concerns is consistent with previous studies (Conway and Briner, 2002; Morrison and Robinson, 1997; Pugh, Skarlicki and Passell, 2003) which suggested that conflicts between expectations and

work experiences can trigger perceptions of psychological contract breach which can cause low mood, a reduction in wellbeing and an increase in organisational cynicism.

The nurses' perceptions of lack of support and, consequently lack of trust in their managers and other colleagues, made socialisation difficult and led them to withdraw from interactions with colleagues. For a group such as the nurses, from a collectivist society like West Africa that thrives on group interactions (Markus and Kitayama, 1991), it is perhaps not surprising that the findings suggest that the nurses' responses of self-withdraw affected their senses of wellbeing. The findings further suggest that the nurses' retaliatory behavioural responses to take up parallel jobs in other organisations, was not only to earn extra income but also to demonstrate their dissatisfaction with their experiences at their primary places of work. The fact that many nurses refused to cover shifts or do 'overtime' at primary places of employment while working the same hours at a different organization, is testament to their reduction in organizational commitment. These behaviours were found to be targeted at their managers and colleagues who they perceive would benefit from the nurses' acceptance to cover those shifts and extra hours.

However, the impact of multiple employments on the nurses' wellbeing was reported in relation to the effects of long hours of work, sleep deprivation and lack of co-worker support and emotional attachment at work. One of the concerning findings of the research is the nurses' reluctance to seek any occupational or mental health support as well their determination in most cases not to call in sick at work even when they were not feeling well enough to go to work. While this reported outcome is consistent with the theories of support and burnout (Cooper, Dewe and O'Driscoll, 2001) which suggest that lack of feelings of cohesion, inclusion, and organisational support, predisposes individuals to burnout experiences, lack of support leading to burnout could present in relative levels to groups. Burnout as a consequent of lack of social support is more likely to be experienced by individuals such as West African nurses from collectivistic cultures with strong communitarian values (Shelton, 1964) who decided to self-withdraw with limited social attachment as immigrants. This finding also relates to previous study ((Babatunde-Sowole, Jackson, Davidson, and Power, 2009) who argued in their finding that failure to integrate into a new society could create mental health problems for migrants. In the nurses reported perception of

lack of support, self-withdrawal and presenteeism, they reported reluctance to engage to assess their mental health conditions as a result.

In contrast with their pre-migration expectations of enhancing their skills and knowledge in safe working environments in the United Kingdom, the nurses felt they were neither working within emotionally safe work environments nor being exposed to new skills and knowledge. While there are arguments (Chandler and Kram, 2007) that people who desire personal development create the thoughts and initiate own development needs and contacts, the nurses, in the context of this findings were not taking the initiative to meet their development needs. However, the explanation for this may be found in the nurses' reliance on developmental mentorship and encouragement from their managers which did not materialise in the form of support to prompt them to take up training and career development opportunities at work. While the nurses' reliance on their managers support regarding their development goals reflect expectations consistent with their high-power distance cultures, it is also consistent with previous research (McDowall and Saunders, 2010) that management actions and roles in the form of support are vital in enhancing employee development goals. The nurses reported not being valued or recognised for their skills, and being excluded, and denied support at work.

The nurses accounts that their managers expected them to do tasks that were the carers' responsibilities was perceived by the nurses as a deliberate act by the managers to undermine their training as nurses. This finding is consistent with previous research (Nichols and Campbell, 2010; Rosenkoetter, Nardi and Bowcutt, 2017) that migrant nurses reported being assigned to roles which were disproportionate to their skills and expertise. Given the work environment, disproportionate assignment of roles may be explained by the peculiar environment of nursing homes that do not operate as conventional hospitals where full nursing and clinical procedures and tasks are carried out. However, the nurses reported being assigned to do tasks such as the laundry tasks which should normally be done by their junior carer colleagues undermined their trainings as nurses.

While the nurses felt that management should use of effective feedback to enhance and improve on their performance (Lewis and Zibarras, 2013), they reported that their achievements did not receive positive feedback which was sometimes ascribed to others, such as the white carers and team leaders. The nurses' perceptions of being left in the dark or only being given negative feedback.

The findings suggest that when the nurses lost trust in management efforts to protect and safeguard their interests or support their career mobility, the nurses removed themselves from organisational issues and focused only on task issues at work. This is consistent with a previous study (Kameny, DeRosier, Taylor, McMillen, Knowles and Pifer, 2014) that found that institutional practices and actions could impede the career success of minority groups such as migrants, who may be frustrated out of the system. With the nurses' perceptions that their managers did not show interest in their personal development as part of exchange expectations their level of engagement with work and work activities declined which relates to previous study's (Saks, 2006) finding that employee perception of lack of organisational support could impact on organisational citizenship behaviours.

The nurses' states of mind resulted in their reducing their levels of affective organisational commitment with such retaliatory behaviours of avoiding extra 'overtime' work which could have supported the needs of their organisation in favour of shifts works elsewhere. This finding further supports previous findings (Fleck and Inceoglu, 2010; Macey, Schneider, Barbera and Young, 2009) that employee perceptions of supportive work environment increase affective organisational commitment. When the nurses' experiences were at variance with their expectations, they adopted a self-withdrawal response. This response further alienated them from organisational support and resources and had a negative impact on their emotional wellbeing. However, contrary to previous research (Suazo, Turnley and Mai-Dalton, 2005; Mowday, Porter and Steers, 1982) that found that employee in these circumstances, would consider leaving jobs and even professions, the nurses in the present research did not consider leaving. Instead, they adopted targeted retaliatory behavioural responses and remained unwilling organisational members. The explanation for the nurses' reluctance to leave their organisations could have been that they felt they were not able to access better opportunities elsewhere. However, the nurses also reported of experiences of an intrinsic sense of motivation in caring for the elderly. The satisfaction which the nurses derived from supporting the elderly residents fitted with their socio-cultural reverence for the elderly and reminded them of their elderly parents in their home countries.

The current finding is consistent with a previous study (Conway, Kiefer, Hartley, and Briner, 2014) which found that employees' retaliatory behaviour after perceptions of a breach in an exchange relationship was not directed to the organisation's service recipients. However, the present research finding contrasts with another study (Johnson and O'Leary-Kelly, 2003) which found that employee perception of a breach had no direct behaviour impact on a co-worker. The current research found that the nurses were sometimes reluctant to share professional knowledge and skills. This reluctance to share tacit knowledge can be explained by the nurses' perception that they would not be credited with the shared knowledge and skills, with which they hoped to sustain their respect and leadership as nurses in-charge.

In answer to the research question on how the nurses managed conflicts of expectations and experiences, this research found that in contrast with their expectations, the nurses experienced a lack of engagement with their workplace resulting from basic inability to maintain a high-quality exchange relationship with their managers. As a result of this failures of expectations, the nurses' adoption of the emotional and behavioural responses of self-withdrawal and their feelings of a lack of organisational based self-esteem made them to engage in multiple employments. The additional work in other organisation was found to be a way of renegotiating their expectations through earning extra financial income but also as retaliatory show of displeasure at their primary places of work. The workload and the self-withdrawal had consequences on the nurses' emotional and physical wellbeing for which they were reluctant to seek the necessary support. The findings in this research in relation to the above, highlighted how exchange theories such as the psychological contract provided insights into the nurses' expectations and experiences

9.2.6 Superordinate theme six: Positive reframing

The findings suggest that the nurses perceived conflicts between their idealised expectations and their actual experiences at work. As a result of emotion-draining outcomes in their conflict between expectations and experiences, the nurses adopted, albeit unconsciously, emotional and behavioural responses aimed at restoring some sense of status quo (Grimmer and Oddy, 2007). In their pre-migration expectations of working in a safe working environment, exposure to quality training for enhanced skills and knowledge for professional competences, the nurses reported conflicts with experiences of exposure to high workloads and being excluded from mainstream organisational support and activities and opportunities for training. The nurses, in

the context of these perceptions, and as a direct, immediate response, adopted a self-withdrawal coping strategy whilst exhibiting presenteeism. With such feelings and circumstances which Cooper, Dewe and O'Driscoll, (2001) and Ogbonna and Harris (2004) suggested could cause psychological strain and emotional labour, the nurses felt vulnerable. Coyne, Aldwin and Lazarus (1981) argued that with conflict or demand that drive an individual's resources to the limit, there are usually both cognitive and behavioural strategies to respond, including coping strategies. Coping is considered an intentional cognitive and behavioural measure to manage psychological strains because of stressors (Carver, Scheier and Weintraub, 1989). The nurses' immediate response to the demands on their emotions as a result of the perceived conflicts between their expectations and experiences was to self-withdraw, hence limiting engagements with regards to sharing views and ideas on both work and personal issues with their managers and colleagues. The nurses used self-withdrawal and avoidance as a coping and temporary escape strategy (Boden, Bonn-Miller, Vujanovic, Drescher, 2012). Given their collectivist cultures, the nurses' adopted coping responses which were found to be consistent with previous research (Chian, Hunter and Yeh, 2004; O'Connor and Shimizu, 2002; Oláh, 1985) which reported that participants from collectivist societies adopted emotion-focused strategies in responding to and managing stressors. This may be explained by their common cultural values of relying on families and spiritual entities in dealing with such matters.

However, the nurses further refocused through positive reframing on measures to mitigate their negative perceptions of experiences at work in the United Kingdom. The nurses' general feelings moved from despondency and avoidance measures to positive framing of events and situations through seeking outside social support in mitigating their emotions. For instance, the nurses reported coming to terms with their experiences at work and decided to reassure themselves and to adjust their mindsets. The nurses' experiences prompted them to search for avenues and opportunities for inclusion and identity. African socio-cultural identity orientation determines that one's personal identity is linked to the social identity, which guarantees personal protection and social relevance (Babatunde-Sowole, Jackson, Davidson, and Power, 2016).

Additionally, the nurses' senses of intrinsic satisfaction from engaging with the elderly residents became a positive emotional support. The intrinsic job satisfaction that the nurses reported keeping them at work suggests that it was possible for employees to remain at work

because of what they feel, hence enhancing their normative organisational commitment. This finding goes to suggest that the nurses' negative behavioural responses to their negative feelings at work had no direct impact on the service users but instead targeted at their managers and colleagues whose interests they did not wish to protect. However, it could be argued that the nurses' reluctance to assist their co-workers could be a result of their perception of co-worker involvement in the breach. In the present research, the nurses felt their junior carer colleagues not only disrespected their authority as nurses in-charge but also were associated with denial of access to resources in their organisations.

West Africans share common values about communal co-existence (Bassey & Oshita, 2010). African cultural values support group and communal solidarity with the emphasis on social support and responsibility rather than individualistic existence (Whittaker, Hardy, Lewis, and Buchan, 2005). The search for social identity and community made the nurses engage with their local churches and ethnic organisational social meetings. To the nurses, the communal social meetings, and meetings at their local churches as a congregation provided them with a communal sense of protection and reassurance. While the church conventionally represents a place of worship, in the sense which the nurses embrace it, it also included feelings of the church as a place of refuge and communal interactions. This was consistent with the findings of Chian, Hunter and Yeh (2004) in the United States that Africans adopted more spiritual and family resources as their coping mechanisms because of their traditional and cultural affiliations.

The sense of attachment to families and family lives back home fulfilled a certain kind of need for the nurses. They gained their satisfaction and feelings of family attachment and sense of well-being from continuing to eat and source the local food, which they cherish a lot. The nurses' experiences became a platform for them to revisit the pre-migration intentions of return migration with a fresh sense of purpose. In reframing their thoughts against social values, the nurses revealed their thoughts that re-enforcing efforts to earn British citizenship would be appropriate compensation for perceived lack of improvement on the skills and professional knowledge for their future career plans. Such feelings would make them feel much better in consideration of their social rating back in their home countries.

The nurses would rather rebuild their lives in the United Kingdom and visit home occasionally than face their peers back home who have advanced in their careers. The sense of “saving their faces” further interprets their cultural disposition towards the face-saving characteristic of protecting personal and family social images. The nurses’ doubts about making an immediate return migration, based on their perceptions of unmet expectations, is consistent with Simeons, Villeneuve and Hurst (2005) and Yeates (2010) arguments that migrants are more likely to make return migrations if their expectations are met in destination countries.

This research examined as part of research Question 3 of how West African migrant nurses coped within the circumstances of their perceptions of experiences at work. The findings suggest the nurses had phases in their coping regimes. Initially, the nurses went into self-withdrawal, consciously avoiding efforts to engage in organisational socialisation. While this approach seemed effective as a short-term, escapism measure, it proved counterproductive because the nurses were up against the same cultures of cohesion, group allegiance and solidarity which sustain their wellbeing. Consequently, the nurses experienced further alienation and lost out on easy access to the resources and information that they could have used to advance their careers and positions at work. However, a further coping strategy that seemed longer-term was the nurses’ engagement with outside organisational social support groups such as local religious groups, ethnic associations, and families back home. The nurses also engaged in renegotiating their exchange relationships, with their involvement in multiple employment for extra income. This had mixed outcomes for the nurses. While it proved materially satisfying in terms of their expectations of meeting their material and financial obligations back home, it pushed the nurses into experiences of psychological strain and burnout.

Chapter 10: Conclusions and suggestions for further research and improvements in practice

This research provided insights into all issues raised in its objectives and questions. The research explored the following research questions: 1) *What reasons and expectations do West African migrant nurses use to explain their migration to the UK?* (2) *How might cultural conceptions explain West African migrant nurses' perceptions of experiences at work in the United Kingdom?* (3) *How do West African migrant nurses manage conflicts between their expectations and experiences?*

With regards to research Question 1, findings from study one suggest that the expectations of West African migrant nurses in the UK varied. However, contrary to previous research suggestions of African migrants being driven primarily by economic reasons, the current findings suggest that while reasons and expectations for economic benefits are not dismissible, West African migrant nurses in the United Kingdom were also driven by other reasons such as the desire to enhance skills and knowledge and the desires to work in a safe and conducive work environment as well as other personal and socio-cultural reasons. The economic reasons reported were indirectly linked to the expectations of the nurses' ascribed responsibilities from both their nuclear and extended families within their collectivist society. Previous studies, including Withers and Snowball (2003) revealed limitations in their articulation of what constituted migrant nurses "unmet expectations" in their reported negative experiences in the UK (Alexis and Vydelingum, 2005). The present research findings contributed to closing this gap by providing additional knowledge and evolving insights into migrant nurses' expectations.

In relation to research questions 2 and 3, the findings suggest that the West African migrant nurses engaged in the process of evaluating their expectations and experiences at work. In these processes, the nurses deeply held cultural values were reflected not only in their perceptions of their experiences but also to a large extent, in how they managed and coped because of their perceptions of their experiences. This present research argues that West African migrant nurses who work in the United Kingdom experienced cultural shock at work because of the cultural distances between West Africa and the United Kingdom. The sections below which summarise the main findings will also argue how the negative outcome following the nurses' perceptions of experiences at could be avoidable and manageable.

10.1 Deeply held values in perceptions

The present research findings suggest that while participants in this research had all good intentions from their pre-migration expectations, to get on with their duties as professional registered nurses, their fundamental hold on to their original cultures in their perceptions of experiences relating to work processes and interactions at work had implications on their perceptions. This finding provided insights and additional knowledge into previous studies, including Alexis and Vydelingum (2005), which reported migrant nurses' negative perceptions of their work experiences but suggested further exploration of issues of culture in research of such experiences. While holding on to own cultural values may seem insignificant, however within context of the nurses' anticipation of engagement and involvement in their organisational mainstream of events, the dynamics, and nurses' perception of inherent imbalances in power relations at work impacted on these expectations of full organisational involvement. Drawing from the LMXD concept, the nurses' perceptions of delayed interactions between their managers and carer colleagues created feelings of an ingroup and outgroup environment. Given the nurses high-power values, this created tension and subsequently fear and distrust as well as further feelings of frustration for the nurses.

The findings suggest the nurses' deep hold on cultural values in their perceptions of experiences at and in their emotional and behavioural responses to work experiences, had an indirect negative impact on the fulfilment of their expectations at work. This is consistent with previous research (Bonvillain, 2013; Teklead and Taylor, 2003; Thomas, Au and Ravlin, 2003) findings that migrant nurses with tight hold on the cultural values are more likely to report negative experiences at work. The explanation for this in the present research was found in the nurses' adoption of avoidance and self-withdrawal strategies. This not only limited their organisational socialisation for support, but also denied them access to organisational resources. Many of the nurses, regardless of the length of their stay in the United Kingdom, reported similar perceptions of experiences. This is contrary to previous suggestions (Berry, 1997; Cameron and Lalonde, 1994) that the anticipated length of stay in a destination country by migrants often leads to a high degree of effort to acculturate. The current findings suggest collaborates previous research (Cohen-Charash and Spector, 2001; Erez and Earley, 1993; Erez and Ayman, 2007; Fiske and Taylor, 1994; Gelfand, Erez and Ayman, 2007; Markus and Kitayama, 1991; Tsui, Nifadkar and Ou, 2007) arguments about how cultural values influence

information processing and determination of choices of actions within social and organisational settings.

10.2 Significances of power and authority bases

The findings suggest that the nurses anticipated relationships with their managers are essential to them. For a group from a background that thrives on communal existence and patriarchy, always looking out in organisations for the power base or point person, the nurses' expectations in the current research were for a strong relational exchange with their managers, notwithstanding a complementary sense of power demarcation. This research argues that managers' appreciation of this sensitivity would be crucial in driving inclusivity at their workplaces and needs not be overlooked or undermined. This research also argues that the nurses' responses through avoidance coping, and voluntary withdrawal could be avoided if managers are responsive and relational enough to understand the early signs of the nurses' withdrawals.

Managers should be proactive with migrant nurses by holding frequent informative chats. It is crucially important for the managers to understand that the nurses would feel more secure with this sense of proximity with managers. Alternatively, interventions from higher management levels should be considered. An in-house cultural champion could be appointed or nominated by the organisation. This person may sit at the organisation's head office and be positioned to earn the trust of the migrant nurses by making occasional visits to engage with the nurses on their work and personal family-related matters.

Contrary to any feelings that this could lead to encroachment on the personal affairs and spaces of the nurses, it would increase both perceived organisational support (POS) and perceived supervisor support (PSS) and subsequently increase the nurses' trust and feelings of well-being. West African nurses' fear and apprehensions were found to be about the divulging of personal information given on trust. The nurses' concerns were that information given may be disclosed to persons who may confront the migrant nurse concerned. These perceptions were exacerbated by managers and colleagues socially distancing from them, which was not helped by the nurses' adoption of the avoidance coping and self-isolation strategies that created further gaps in relationships. The nurses are sensitive to their face-saving socio-cultural backgrounds, therefore any issue or process that could violate this should be avoided, including holding on

to their non-adversarial information. So, any personal information they give should be held and managed as such. This is also consistent with modern management guidelines on personal data management such as the general data protection regulation (GDPR).

10.3 Organisational social support

The nurses' use of outside social support systems to adapt within the circumstances suggests the strong influence of social support on employees from a collectivist cultural orientation. This research argues that, with a welcoming platform that could be provided by recognising the hidden challenges the nurses face, there could be a different socialisation outcome. While the migrant nurses were introduced to some basic symbolic value practices in the United Kingdom, such as tea and coffee drinking, as well as smoking, which serve as platforms for socialisation, the non-recognition of the migrant nurses' sensitivities reinforced the barriers to socialisation and communal sense of being.

Tea and coffee sessions, as well as smoking breaks, form platforms for socialisation and bonding in the United Kingdom. The British take pride in offering and being offered a cup of tea or coffee as forms of courtesy and socialisation. This also goes for group cigarette smoking. However, for West African migrant nurses, from backgrounds where smoking is seen as "special habits", smoking and tea and coffee are not necessarily part of traditional ways of their nutritional nor social lifestyle practices. These were perceived as exclusionary rather than inclusive behavioural practices. This research argues that while these socialisation sessions resonate well among the native British staff, these present and remind the migrant nurses' platforms of segregation rather than inclusion.

The nurses perceived these periods when their carer colleagues and managers were socialising without any attempts to involve the nurses, as being used to gossip about their work or persons. Arguments (Fischer and Smith, 2006; Markus and Kitayama, 1991; Thomas, Kevin and Ravlin, 2003) that intergroup dynamics in differences in values, interests and expectations would, in cases, breed negative perceptions and interpretations of actions and behaviours of others during interactions and socialisation at work resonate in this circumstance. While some native British might see smoking sessions as emotion regulating sessions that help them at work, the migrant nurses perceive these as unfair considering the multiple times the staff go out for these smoking breaks and the additional workload that can arise within the same period for the

nurses. This research suggests that management considers of alternative forms of compensation for the nurses as appropriate within the work environment.

Given the findings of the importance for the nurses, of “food from home”(meaning cultural food delicacies), this research therefore suggests that organisations employing migrant nurses should consider creating a common room for multicultural cuisine. This should be introduced with caution so as not to create a segregated workforce. This would create a sense of inclusion because the nurses would have a space to conveniently share their cultural or local food. As an alternative to this suggestion, organisations could promote cultural diversity by setting out a day within a period to promote cultural food. It was evident from the findings that West African nurses engaged passionately with their ethnic food and artifacts which, increased their sense of well-being and identity. It is obvious that managing a diversified workforce needs skills. Following the present research findings that the migrant nurses felt isolated due to their perceptions that their managers related more with their white carer colleagues, this research suggests management searches for a common ground for inter-group collaborations. This is achievable if managers position themselves in-between groups and encourage relationships with employees based on skills and knowledge and contributions to the organisational goals, while also applying humane approach to the relationships. .

10.4 Avoidance coping and disengagement

The nurses’ adoption of avoidance coping as a proximal emotional and behavioural response to their perceptions of experiences at work further alienated them from their organisations’ socialisation and interactional processes. The vacuum created by the nurses’ adoption of non-voice and avoidance approach, consistent with their cultural values, was reflected in their passive approach to interactions and conflicts at work which then led to their inability to negotiate for organisational resources and engagement for their well-being and career development. This created more trust and commitment issues with attendant consequences for both the nurses and their organisations. Most of the female nurses, who formed the majority of the participants in the research, unlike male nurses, reported more susceptibility to low moods, suggesting that social isolation had a greater impact on women than men, especially from collectivist, patriarchal societies. This may be explained by other issues which could be

determined in future research. The present research argues that the nurses perpetuated their hold on their own cultural attributes because of their loss of a platform to engage in a positive and progressive sense of acculturation, hence their renewed search for community and identity. Further findings suggest that the nurses' adoption of positive reframing as their coping measure sustained their motivation to stay at work. With perceptions and conclusions that their pre-migration expectations seemed unfulfilled, the nurses' thoughts of return migration became reversed. This again was the result of socio-cultural issues of saving face in home countries. Consequently, the nurses adopted more transactional relationships at work in contrast to earlier expectations of increased relationship exchange relations. This was evidenced in the nurses' engagement with multiple jobs. While it was not verified in the current research, the nurses' levels of commitment and performances in their second or third jobs, it would make interesting further investigations. Such investigation is essential given the primary motivation which the current research revealed as the reasons for the nurses' engagement in second and third jobs on extra earnings and restoration of equity feelings. This further investigation is also necessary following the nurses' reports of emotional and physical impact of these extra engagements may have on the nurses.

10.5 Primacy of trust

Migrant nurses, based on the findings of the present research, are sensitive to the information they give out, either in the process of seeking socio-emotional support or for conventional reasons. Divulging information that the nurses would consider personal either through social humour or deliberately sharing the same could be emotionally traumatising for a group that has a high propensity for risk and conflict avoidance. The nurses' expected that communication about what they have done or are expected to do should be communicated to them directly from the managers. In this way, they feel recognised and develop feelings of a sense of support from the manager. The nurses' expectations of being accorded respect at the level and recognition of their positions as nurses-in-charge seem lost as a result of their perception that managers interact more with the white carers.

This research suggests that management should design platforms to encourage communication and feedback to develop a culture of trust. Trust was found to inform the foundations of the nurses' gateway into their organisation's social and engagement domains. The research argues that the migrant nurses' managers and colleagues were ill-equipped to understand the nurses'

socio-cultural circumstances. This apparent ignorance of the nurses' circumstances created interactional vacuums and subsequent issues of trust resulting in low manager-employee exchange relationships.

The present research findings revealed that cultures operate underneath and need to be observed. The ignorance of both the nurses and their managers and colleagues of their different hidden values created substantial challenges in their work relations. While previous research (Likupe and Archibong, 2013; Likupe, 2006) provided some understanding on the experiences migrant nurses in the UK, the present research evolved further insights on management understanding of peculiar values of migrant nurses and recommends that managers adopt micro-measure approaches in their interactions with their overseas nurses and sustain these interactions on the fundamental block of trust between them. This research suggests a trust-building framework that involves occasional informal brief sessions between managers and individual migrant nurses about their views on issues to make them feel that their opinions and views count. These sessions should not be confused with the informal sessions to discuss the nurses' personal and family matters. It is the position of the present research that if managers take just few minutes during the day to engage with individual migrant nurses, that will go a long way to reassure and create feelings of acceptance. In turn, the organisational outcomes of this will lead to improved relationships and collaboration. The nurses were found to be comfortable with communal identities. Management actions to develop platforms for migrant nurses to realise their cravings for a communal life will create welcoming and collaborative environments which will be the antecedent for the realisation of the positive gains of diversity at work.

Many of the nurses do not like making contributions in the open or during meetings. This does not mean they do not have opinions, but they are conscious of verbal and nonverbal criticisms that they feel they may receive as current findings suggest. This research argues that this can get better with management appreciation of the cultural influences on the emotional and behavioural responses of migrant nurses and the adoption of appropriate corrective actions. Even when decisions have been made, a manager's or supervisor's regular personal engagement and conversations with the nurses would reassure them of inclusion in the decision-making processes. The nurses would always be looking for opportunities like these to feel included. The West African nurses in this research were found to be measured in their

approach to these issues, mostly looking for the most comfortable and less “being on the spot” opportunity to express opinions over issues. The nurses’ views expressed at such times are particularly important to them. Managers of migrant nurses should aim to reflect on those views and make them feel in any practical way possible that these have been taken on board.

The nurses’ reluctance to express their views in meetings may be observed even in the articulation of their ideas on issues. The nurses may initially feel uncomfortable, especially in a setting of more than a person, about getting their expressions right because of their perceived language weaknesses and their sensitivity about both verbal and nonverbal reactions to both their presentations and suggestions. However, given the right space and time, the nurses may feel more comfortable to flow with their ideas. Therefore, managers and colleagues of migrant nurses, as a form of socio-emotional support, should feel freer to engage in one-to-one sessions with them. This does not compromise the personal space of the nurses’ but rather helps to build and sustain bonding. West African nurses, consistent with their cultural background, thrive on trust and concerns about their nuclear and extended families and do not take offense (Ubeku, 1983) when managers show interest in their private family issues, especially in one-to-one trust-based chats.

In an organisational exchange relationship, there are two sides to the contract. This research highlighted issues of concern regarding migrant nurses’ expectations and perceptions of experiences within the framework of their cultural conceptions. The research has equally suggested that future research should include the nurses’ managers in the investigations. This is contingent on the assumptions that the migrant nurses’ managers who were referred to in this research would not have had any idea about the nurses’ held expectations and experiences, given their subjective nature. This research argues that the issue here may not be awareness or otherwise of cultural issues but the motivation to be aware of cultural issues.

To develop this mindset for the managers, this research suggests that all potential appointees to management positions in nursing homes in the United Kingdom should be prepared, as part of their induction, to be introduced to cultural intelligence (CQ) (Earley and Ang, 2003) awareness training to induce a fundamental appreciation of cultural differences. This is neither a suggestion for the basic awareness training nor that managers should learn different cultures of the world, but that they should be introduced to the awareness of the need to engage in cultural awareness programs and willingness to adapt within reason to adopt measures to

manage possible differences in values. Migrant nurses, as part of their NMC adaptation program, should also be introduced to similar forms of orientation.

10.6 Occupational (mental) health concerns

One of the other interesting and important conclusions of this research is on the nurses' repressions of their negative emotions. While this represents a form of defensive mechanism in the short run, this could have consequences on individual's mental health (Turner, 2011). There is little wonder of the nurses' revelations of concerns on their mental health at work. On these concerns, the nurses were also reluctant to seek support because of the fear of labelling and "clinical indictment" that could make it difficult for them to keep their jobs. This research argues that, while it is appreciated that it is the nurses' primary responsibility to take care of their health, mental or physical, organisations should create units or site personnel within their occupational health units to be solely responsible for listening to and supporting the nurses on their personal health concerns, especially mental health issues. Many of the nurses behave as normal and carry on with their daily lives but their minds are in "prisons" because of experiences at work. It is worth seeking to understand trusted and non-destructive ways of supporting migrant employees who are exposed to emotive and stressful work environments. While management of the nursing homes cannot entirely take the blames for these situations, this finding has huge practical management implications. The culture champion, as suggested, can take up the challenge of addressing the migrant nurses' concerns given the level of trust earned amongst the nurses.

10.7 Summary of research contributions to knowledge and practice

This research's objectives are: 1) To extend understanding of expectations and experiences of West African migrant nurses in the United Kingdom. 2) To offer insight into the emotional and behavioural responses of West African migrant nurses to their perceptions of experiences at work in the United Kingdom. Further to the above objectives, the research evolved insights with both theoretical and management practice implications. While previous research, as highlighted in literature, provided evidence for the negative experiences of migrant nurses in the United Kingdom, the current research evolved deeper insights into the complex interactions of expectations, cultural understandings, and responses to the experiences of West African migrant nurses in the United Kingdom. The qualitative nature of the present research enabled the evolvment of insights into the nurses' cultural perceptions of power relations and how these perceptions impacted on their relationships at work in the United Kingdom.

The nurses' feelings of high leader member exchange differentiation reinforced their perceptions of negative experiences and further increased their isolation at work. While the nurses had anticipated high trust-based leader member exchange relationships which could have positively impacted on their perceptions of organisational processes, their real experiences of high leader member exchange differentiation rather created tension and distrust for the nurses.

This research created deeper insights for the management implications of the nurses' emotional and behavioural responses following their experiences at work. The nurses' responses following their experiences were not overt but rather subtle. For instance, the research findings suggest that the nurses' rather concerning non-voice (repression of emotions) and avoidance approaches in managing their perceptions of negative experiences should be a 'wake up' call for management. While migrant nurses may not necessarily speak through their legs by walking away from their organisations in response to perceptions of negative experiences, the non-appreciation of the nurses' perceptions of negative experiences and lack of prompt management could be detrimental to both migrant nurses and their organisations. This could have implications for the nurses' mental health and their levels of organisational commitment.

Therefore, this research proposes practical steps that the management of organisations employing migrant nurses could apply to increase understanding and management of the cultural sensitivities of the nurses' and their support needs, to reduce tension and distrust at work and consequently enhance the nurses' engagement in and membership of their organisations. This research proposes that it is necessary for the effective leadership of organisations to champion the processes of initiating, building and sustaining trust between migrant nurses, their managers and colleagues. It is important for management to assess and appreciate the nature and forms of organisational support that migrant nurses anticipate at work. The nature of this support may not be obvious as one would expect but rather present in implicitly coded expectations. This is complemented by the theoretical assumption (Turner, 201:23) that "when...expectations associated with identities are not realised...expectations arising from our social and co-identities, individuals will experience intense emotions"

While the current research acknowledges Aju and Beddewela (2020)'s suggestions and consistent with current findings, the need to consider traditional cultural values in management, the present research further argues in support of Iwowo (2015)'s suggestion for a hybrid approach of engaging with both mainstream organisational practices and indigenous values for effective work process and engagement. The current research proposes that whilst migrant nurses' cultural values might have inevitable influences on their information processing and determination of choices at work, it is also possible for them to adapt and adjust outside of their culture to gain advantages at work to meet also expectations of their organisations, hence the present research proposes support for both managers and migrant nurses to develop cultural intelligence (CQ) skills as part of their induction and pre-practice adaptation processes respectively at migration destinations, including the United Kingdom. There will always be the need for migrant nurses in the United Kingdom, hence the relevance of the findings and contributions of this research.

10.8 Suggestions for future research

While this research has evolved deeper insights into migrant nurses' experiences in the United Kingdom, the researcher suggests that some issues which emerged from the current research should be explored further. These issues include:

1. What are the proximal and distal implications of married migrant nurses' separation from their families ?
2. What is the role of trust in mitigating migrant nurses' perceptions of intrusive micromanagement from their managers?
3. What are the consequences for migrants' wellbeing and service standards and delivery following lack of access to occupational health support?
4. Are their generational explanations for migrants' hold on to previous cultural schemas in perceptions in contemporary organisations?
5. Does social class of individual employees play any role in multicultural and intergroup relations at work?
6. What are the hopes for African professional migrants on return migration without post retirement social safety nets in home countries?
7. What are employee commitment implications on parallel employment through "agencies" in nursing homes?

Each of the issues above suggests further factor could impact on migrant the nurses' wellbeing and reactions to their work experiences.

10.9: Limitations of the research

This is an exploratory phenomenological research investigation. The purposive sample population of fifteen nurses, even though it is considered appropriate for the research and methodology used, is small and the area covered in the sample may not be representative of the entire population of West African migrant nurses in the United Kingdom. It is therefore advised that, in generalising the findings of the research outside its context, a caveat is applied. With regards to methods, any future research any future research may consider using other approaches, such as the longitudinal research approach, to obtain data on a real-time basis, even though this may have its own challenges. Future research should also consider using different methods that would expand the sample population across other Western countries. The

ethnography and diary methods could be applied. These could work in considerations of migrant nurses who would rather not be involved in one-off face to face oral interviews but would prefer method which would make them feel more “anonymous”.

This research focused on the nurses’ side of the story. The researcher suggests that future research on cultural implications of the migrant nurses’ experiences should consider including their managers and/or white colleagues. While the nurses’ accounts represent their expectations and experiences, there could be some elements of social desirability responses because of expressions of emotions at the time of the interviews. So, it will serve a great purpose, therefore, to further expand the insights from the British managers and colleagues’ sides to broaden understanding of the experiences, especially with the insights already generated from the current research. Similarly, given that in recruiting for the participants, even though exclusive criteria were drawn, the researcher did not control for possible variables such as age or gender, it may be possible that generational differences could produce different experiences even with the same cultural conceptions.

In the process of both data collection and analysis, there were language challenges for both the researcher and the researched. Even though most of the nurses had their training and education with the English language as the medium of instruction, the use of English language seemed difficult in defining thoughts and ideas. Therefore, for want of appropriate words to describe issues or events, the nurses may have chosen to give slim or brief responses to issues that otherwise might provide richer, more detailed data. While the researcher had ample time to adjust for the challenges these posed, it is recommended that an alternative method of data collection that would provide real-time data should be used in some other future research involving migrant nurses with English as a foreign language. Alternatively, the interview could be conducted in a native language and later interpreted, peer-reviewed and double-verified with the nurses before analysis. This research involved a sample population of West Africa migrant nurses working in private independent nursing homes. Even though it was an exclusive criterion, the experiences of nurses, whether West African or other migrant nurses working in the public health service (NHS), may vary. This researcher, therefore, suggests future research to include the experiences of nurses working in the public health service. Alternatively, a detailed comparative study is suggested to examine experiences in those contexts. While appreciating all the above limitations, the researcher applied all necessary processes to ensure

that the outcomes of this research represent insights that make valuable contributions to knowledge and practice.

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Appendices

Appendix (i) Participant recruitment notice



Recruiting research participants

Attn.: West African nurses

I am conducting a PhD research on the subject of Understanding West African migrant nurses' experiences at work in the UK: A phenomenological study. This notice is for nurses of West African origin who are currently working in nursing and care homes in the South East of England ,including London who may be interested to participate in the research.

It is a research which aims to develop insights into the expectations and perceptions of the nurses at work in the United Kingdom. Participation in the research will involve the following:

- Your participation is unpaid and voluntary
- You will be interviewed, and researcher will request your permission to audio record the interviews
- You will be required to participate in two separate interview sessions, each lasting no more than 60 minutes.
- The researcher will respect and honour your choice of interview venues, time, and date
- You may withdraw from the research at any stage and request that your data be removed.
- This research is purely for academic purposes and has no commercial value.

Are you a nurse, originally from West Africa and may wish would participate in the above research? Please do contact me through any of the following media for further details on the research.

My contacts details are as follows: Chinedu Uwabuik Department of Organizational Psychology (PhD Room), Birkbeck University of London WC1E 7HX, Bloomsbury Campus. Telephone: 079xxxxxxx Email: cuwabu01@mail.bbk.ac.uk

Thank You.

Appendix ii : Participant formal letter of invitation



Dear xxxx

Invitation to participate in research

Research Title: Understanding West African migrant nurses' work experiences in the United Kingdom: A phenomenological study

I am currently conducting a PhD research on the above topic at the Department of Organisational Psychology Birkbeck, University of London. The research is of two studies design, meaning that data for the research will be collected in two separate interviews with you taking part in both interviews. In the first phase of the interview, data will be collected on the reasons and expectations of West African migrant on their migration to the United Kingdom. In the second phase of the interview, data will be collected to explore the nurses' perceptions of their experiences at work.

You may ask to withdraw at any stage of the process and request for the removal of your data. All data collected are to be used solely for the purposes of this academic research. There is no commercial value(s) attached to the research. No identifying personal details shall be requested during the interview or included in the research to ensure your anonymity. However, I will be requesting for your permission to audio record your interview responses and these would be destroyed as soon as the analysis are completed.

You may request a call back for me to contact you to arrange a date, time, and place convenient for both of us for the interview. Meanwhile, should you have any queries, concerns and or need for further clarifications, please contact me via email: cuwabu01@mail.bbk.ac.uk (Tel: 079xxxxxxx) or Dr Julie Dickinson Dept. of Organisational Psychology, Birkbeck, University of London. (Research Supervisor) Email: j.dickinson@bbk.ac.uk.

Thanks in advance for your co-operation.

CHINEDU UWABUIKE (PhD Candidate)

Appendix iii Participant Consent form

Department of Organisational
Psychology



Research Title: Understanding West African migrant nurses' work experiences in the United Kingdom: A Phenomenological study

Researcher: Chinedu Uwabuiké

Research Supervisor: Dr Julie Dickinson

Dear Research participant

Further to my letter of invitation for your participation in the above research, can I request that you read and sign part B of this letter below to confirm your full understanding of what this research aims to achieve as well as what your participation involves, please.

PART B

I have been informed, read, and fully understand the objectives of the above research.

I understand and agree to be interviewed during the two phases of the research.

I understand and give my consent for the researcher to make audio recording of the interviews. The data collected will only be accessible to the researcher, supervisor, and any authorised faculty member of the University.

I understand that the data collected will be used only for the academic research as mentioned above. The data will not contain any identifying details of my person or my organisation.

Data will be stored securely and destroyed within reasonable time after analysis.

I understand and voluntarily accept to participate in the research and may withdrawal if I so wish at any time and request that my data be removed.

Name of Research Participant:

Signed:

Date:

Appendix iv Interview guide for Study One

1) Tell me about your choice of nursing as a career?

2) Let us talk about your reasons and expectations in your decision to migrate to the United Kingdom to work as a nurse? (Researcher's probes as below)

- *Tell me about your work experience in your home country before you migrated to the United Kingdom*
- *What issues, as your reasons, made you decide to migrate to the United Kingdom?*
- *Tell me about the challenges (if any) that you faced in your decision to migrate to the United Kingdom, please.*
In your thoughts, how would summarise your expectations based on your reasons to migrate to the United Kingdom to work as a nurse.
- *As a trained nurse practicing in your home country, did you have other options to migrating to the United Kingdom at the time you did migrate ... Please tell me about it.*
- *How would summarise your feelings so far at work?*

Appendix v Interview guide for Study Two

1 Demographic data

- (a) Are you a West African by birth? Yes No
- (b) Gender: Male Female
- (c) Age: 18-25 26-35 36-45 45-55 55-Above
- (d) Relationship Status: Married Single Divorced Separated
- (e) How long have you lived and practiced as a nurse in the UK 2-5years 6-10 11yrs+
- (f) What is your immigration status in the UK (a) Naturalised (b) ILR (c) Work Visa
- (g) Did you have your nursing training in West Africa? Yes No
- (h) Do you have at least 2years post training work experience in West Africa? Yes No
- (i) Did you apply for pre-practice registration with NMC from your home country? Yes No
- (j) Did you go through the NMC's overseas nurse's adaptation programme Yes No
- (k) Are you currently working under the supervision of a native British manager? Yes No

2 Participants profile : *During the first study of this research, you told me briefly about your career, can you please tell me about your person and family background?*

3 Workplace environment and relationships Let us talk about your current work environment and relationship (Researcher's prompts below) *Tell me about the persons at your workplace that you have direct interactions with in performing your daily tasks?*

4 Perception of actions and behaviours

Tell me about specific actions or behaviours of your manager or colleagues at work in relation to your work relationship expectations? Can you tell me about when felt pleased with how you were treated at work in your interactions ? Can you tell me about when you felt not treated well at work in your interactions?

Can you tell me how such actions and or behaviour made you feel in terms of your emotions and reactions at the time you perceived them ? ; How would you say those actions and or behaviours from either your manager or colleagues affected you or how you do your work?

Given your emotions because of those perceived actions and or behaviours of your manager or colleague ,tell me how you manage to continue to stay on to do your job; Do you still hope to continue to work in the UK as a registered nurse?

Appendix vi Birkbeck, University of London research ethics form

Organizational Psychology Ethics Form Proposal to Conduct Research Involving Human Participants

Before completing this form make sure you have familiarised yourself with BPS Core of Human Research Ethics

If you are conducting internet research, please read the AoIR recommendations for ethical decision making before completing this form

Section A:

Name(s) of Investigator:	Chinedu Uwabuike
Date of application:	2011
Proposed start date:	2011
Contact details: Email	cuwabu@mail.bbk.ac.uk
Status (e.g. Lecturer, PhD student, BSc/MSc student)	PhD Student
Supervisor (name and email) (if applicable):	Dr Julie Dickinson J.dickinson@bbk.ac.uk
Funding source (if applicable)	NA
Project Title (15 words max)	Understanding West African migrant nurses' work experiences in the United Kingdom: A Phenomenological study

Are any committees other than this one evaluating whether your proposed research is ethical? NO

If yes, include the proposal you made to them and (if available) their decision

Section B: Supporting Documentation

Listed below are the materials you need to include with the ethics submission. Please place an X in each box when you have ensured that this material is included with your submission.

Note that if you are seeking ethical approval for a survey your only need to submit the questionnaire if you are using your own questions. If you are using existing, published questionnaires, you do not have to

attach the questionnaire, but you do need to explain which questionnaire(s) you are using (and provide references) in Section D.

Under the “Other” option you may specify (and attach) any other documents that you consider relevant to your application. For example, you can include an ethics application form that has been submitted to a different committee. If you are debriefing the participants, you need to include the relevant documents here. Note that debriefing is not compulsory unless you are actively misleading or deceiving the participants as to the purpose of the study.

For projects that will run over multiple years and may involve multiple data sources it is recommended to include a data management plan. This is also required if you are applying for ethical approval for a funding application or a funded project.

Information Sheet	X
Consent Form	X
Materials used (e.g. questionnaire, interview schedule) (where appropriate)	X
Other (please specify):	

Section C: Checklist

Will the participants be required to experience unpleasant stimuli or unpleasant situations? (this also include unpleasant experiences that may result from deprivation or restriction, e.g. Food, water, sleep deprivation)	NO
Will any information about the nature, process or outcome of the experiment or study be withheld from participants? (if information is withheld, the participants will need to be debriefed after the data collection. In addition, a second informed consent to use the data should be obtained after debriefing the participants)	NO
Will participants be actively misled or deceived as to the purpose of the study? (if the participants are actively misled or deceived, they need to be debriefed after the data collection. In addition, a second informed consent to use the data should be obtained after debriefing the participants)	NO
Will participants receive any inducement or payment to take part in the study?	NO
Does the research involve identifiable participants or the possibility that anonymised individuals may become identifiable?	NO
Will any participants be unable to provide informed consent? (e.g. minors, people who may lack capacity to do so, people in an unequal relationship forced to participate, etc)	NO
Might the study carry a risk of being harmful to the physical or mental well-being of the researcher in carrying out the study? (any risk above the normal risk expected in everyday life should be reported here)	NO
Might the study carry a risk of being harmful to the physical or mental well-being of participants? (any risk above the normal risk expected in everyday life should be reported here)	NO
Might the study carry a risk of being harmful to the College in any way? (e.g. reputation damage, security sensitive research such as military research or on extremist or terrorist groups, research requiring illegal/extreme/dangerous materials)	NO
Will the research involve any conflict of interest? (e.g. between your role at work and your role as a researcher? will you want to use data/colleagues that you have access/contact with in your job but as a researcher they would not normally be available to you)	NO
Is there any possibility of a participant disclosing any issues of concern? (e.g. legal, emotional, psychological, health or educational.)	NO
Is there any possibility of the researcher identifying any issues of concern?	NO
Are there any other ethical concerns that you are aware of?	NO

If you answered '**YES**' or '**DON'T KNOW**' to any of the above; provide further details here; being specific about how you will address ethical concerns in the study protocol:
(you can expand the area below to use as much space as needed)

NA

Section D: Project description

(you can expand the areas below to use as much space as needed)

Description and rationale for proposed project (in accessible terms – what is the research question, how can people benefit, what are potential risks, and how are they mitigated?)

This research project aims to understand the expectations and perceptions of experiences of West African migrant nurses working in the United Kingdom. The research builds on previous studies which found that migrant nurses reported negative experiences whilst at work. With this in mind, the research explored the expectations and experiences of a purposive sample of fifteen (n=15) West African nurses using the qualitative research approach, involving the interpretative phenomenological analysis (Smith, Flowers and Larkin, 2009) and template analysis (King, 2012) techniques. In doing this, the researcher set out with the following objectives: To extend understanding on expectations and work experiences of West African migrant nurses in the United Kingdom; To offer insight into the emotional and behavioural responses of West African migrant nurses on their perceptions of experiences at work in the United Kingdom. In a two-studies research design, with data collected in two separate phases using semi-structured interview methods to answer the research questions:

Description of participants (How will participants be selected? What are the inclusion/exclusion criteria? How many? How will they be identified and recruited?)

Self-selection and Snowballing

Description of Methods (What are the procedures used for data collection? What will the participants be asked to do? Where will the study be conducted? How do you intend to analyse the data?)

This is a qualitative research. Data for the research is collected using semi-structured interviews. Analysis of data is done using both the template analysis and interpretative phenomenological analysis techniques.

What arrangements are to be made to protect participants' anonymity?

Participants identifying details are avoided, hence the use of pseudonyms to replace their real names. Data collected are saved and secured in the researcher's password protected personal computer.

What arrangements are to be made to ensure that the data you collect is held securely and confidentially? (both electronic and hard copies)

Data obtained and used in this research are secured electronically in password protected personal computer, accessible only to the researcher.

What arrangements are to be made to obtain the free and informed consent of the participants?

Consent forms were administered to the participants before interviews. The participants were also given advance notices and their choices of time and venues for the interviews are respected. Notices and letter of invitation to participate in the research also informed the participants on their participation on voluntary basis and may withdraw at any time and have their data removed should they so wish at any time.

If you are conducting internet research, please explain how you have addressed the following issues:

- a. Does your internet research involve human participation?
- b. Does your internet research take place in a private or public internet space?
- c. Is it appropriate to obtain informed consent from those whose data you are using?
- d. Is it appropriate to anonymise or attribute your internet data?

(Please see the AoIR recommendations for a definition of internet research and more details on these issues)

Internet searches for this research were only to access journal articles which are in public domain. In any circumstance(s) where any person's work is used in the research, these are acknowledged.

Section E: Declarations

Please confirm each of the statements below by placing an 'X' in the appropriate space

I certify that to the best of my knowledge the information given above, together with accompanying information, is complete and correct.

I accept the responsibility for the conduct of the procedures set out in the attached application.

I have attempted to identify all risks related to the research that may arise in conducting the project.

I understand that **no** research work involving human participants or data can commence until ethical approval has been given.

Suggested Classification of project by the applicant (please highlight):

	SENSITIVE / EXTREMELY SENSITIVE / ROUTINE	
Signed by the applicant:	CUwabuiké	Date Oct.2011

If you have answered with "Yes" or "Don't know" to any of the questions in Section C, your project should be classified as either "Sensitive" or "Extremely Sensitive". However note that your project may be "Sensitive" or "Extremely Sensitive" even if you have responded with "No" to all section C questions.

Section F: Classification

FOR USE BY SUPERVISORS OR THE DEPARTMENTAL RESEARCH OFFICER

Classification of project (please highlight):

	SENSITIVE / EXTREMELY SENSITIVE / ✓ ROUTINE	
Signed by the Supervisor (if applicable)	J. Dickinson	Date 2011
Signed by the Departmental Research Ethics Officer		Date

